Appendix B: Model Contract

LOUISIANA MEDICAID
MANAGED CARE ORGANIZATION
MODEL CONTRACT

LOUISIANA DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES FINANCING

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PART 1: GLOSSARY AND ACRONYMS

1.1 Glossary

** Denotes terms for which the Contractor must use the State-developed definition.*

1915(b) Waivers – Section 1915 of the Social Security Act, 42 U.S.C. §1396n, authorizes the Secretary of the United States Department of Health and Human Services to waive certain requirements including those necessary to allow the use of Managed Care in the Medicaid Program. Under 42 U.S.C. §1396n(b), states have the following options:

1) 1915(b)(1) - Implement a managed care delivery system that restricts the types of providers that people can use to get Medicaid benefits.
2) 1915(b)(2) - Allow a county (parish) or local government to act as a choice counselor or enrollment broker in order to help people pick an MCO.
3) 1915(b)(3) - Use the savings that the state gets from a managed care delivery system to provide additional services.
4) 1915(b)(4) - Restrict the number or type of providers who can provide specific Medicaid services (such as disease management or transportation).

Abandoned Call – A call in which the caller selects a valid option and either is not permitted access to that option or disconnects from the system.

Abuse – 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 health care.

Actuarially Sound Capitation Rates – Capitation rates that are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the Contract and for the operation of the MCO for the time period and the population covered under the terms of the Contract and are developed in accordance with the requirements of 42 C.F.R. §438.4(b).

Acute Care – Preventive care, primary care, and other medical care provided under the direction of a physician for a condition having a relatively short duration.

Acute Care Hospital – A hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short-term illness or condition). For purposes of determining network adequacy, acute care hospitals must include an emergency department, which may be off-site.

Adjudicate – To deny or pay a clean claim.

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

Adverse Benefit Determination – Any of the following:

- The denial or limited authorization of a requested service, including, but not limited to

determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by the State.
- The failure of an MCO to act within the timeframes provided in 42 C.F.R. §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
- The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Adverse Childhood Experiences (ACEs) – Stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse.

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

1) Owns or holds more than a five percent (5%) interest in the MCO (either directly, or through one (1) or more intermediaries);
2) Is an entity in which the MCO owns or holds more than a five percent (5%) interest, either directly or through one (1) or more intermediaries;
3) Is a parent entity or subsidiary entity of the MCO regardless of the organizational structure of the entity;
4) Has a common parent with the MCO, either directly or through one (1) or more intermediaries;
5) Directly, or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, the MCO; or
6) Would be considered 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.

Ambulatory Care – Preventive, diagnostic and treatment services provided on an outpatient basis.

Americans with Disabilities Act (ADA) – The Americans with Disabilities Act of 1990, 42 U.S.C. §12101-12213, as amended by the ADA Amendments of 2008, P.L. 110-325, prohibits discrimination against people with disabilities in employment, transportation, public accommodation, communications and governmental activities. The ADA also establishes requirements for telecommunications relay services.

Ancillary Services – Those supports other than room, board, and medical and nursing services, that are provided to hospital patients in the course of care. They include services such as laboratory, radiology, pharmacy, and physical therapy services.

Appeal* – A request for a review of an adverse benefit determination.

Appeal Procedure – A formal process whereby an enrollee can contest an adverse determination rendered by a Contractor, which results in the denial, reduction, suspension, termination or delay of health care benefits/services. The appeal procedure shall be governed by federal and state laws and regulations and all applicable court orders and consent decrees.

Attribution – The method used in a VBP model to determine which provider group is responsible for an enrollee's care and costs. Attribution is a mechanism for creating accountability and aligning incentives within a provider group to coordinate an enrollee's overall care needs.

Authorized Representative – Any person who has been delegated the authority to obligate or act on behalf of another.

Automatic Assignment – The process utilized by LDH to enroll Medicaid enrollees into an MCO, using predetermined algorithms, who (1) are not excluded from MCO participation and (2) do not proactively select an MCO within the LDH-specified timeframe.

Basic Behavioral Health Services – Mental health and substance use services which are provided to enrollees with emotional, psychological, substance use, psychiatric symptoms and/or disorders that are provided in the enrollee's PCP office by the enrollee's PCP as part of primary care service activities. Basic Behavioral Health Services include, but are not limited to, screening, brief intervention and assessment, prevention, early intervention, medication management, treatment and referral services provided in the primary care setting. Basic Behavioral Health Services may further be defined as those provided in the enrollee's PCP or medical office by the enrollee's (non-Specialist) physician (e.g., DO, MD, APRN, PA) as part of routine physician evaluation and management activities. These services shall be covered by the Contractor for enrollees with both physical health and behavioral health coverage.

Beneficiary – An individual who has been determined eligible, pursuant to federal and state law, to receive medical care, goods or services for which LDH may make payments under the Medicaid or LaCHIP programs.

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

Business Continuity Plan (BCP) – A plan that provides for a quick and smooth restoration of all Contractor functions after a disruptive event. BCP includes business impact analysis, 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. Central Time.

Business Owner – Individual who is accountable for and is the primary point of contact for a specified business area.

CAHPS – The Consumer Assessment of Healthcare Providers and Systems is a standardized survey of enrollees' experiences with ambulatory and facility-level care established by the Agency for Healthcare Research and Quality (AHRQ).

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

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

Can – A term that denotes an advisory or permissible action.

Capitation Payment – A payment, fixed in advance, that LDH makes to a Contractor for each enrollee covered under the Contract for provision of MCO covered services. This payment is made regardless of whether the enrollee receives any MCO covered services during the period covered by the payment. Also referred to as a PMPM payment.

Capitation Rate – The fixed monthly amount that the Contractor is prepaid by LDH for each enrollee assigned to the Contractor to ensure that MCO covered services under this Contract are provided.

Care Coordination – Deliberate organization of patient care activities by a person or entity, including the Contractor that is formally designated as primarily responsible for coordinating services furnished by providers involved in the enrollee's care, to facilitate the appropriate delivery of health care services. Care coordination activities may include but aren't limited to the coordination of specialty referrals, assistance with ancillary services, and referrals to and coordination with community services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of the enrollee's care.

Care Management – An overall approach to managing enrollees' care needs and encompasses a set of activities intended to improve patient care and reduce the need for medical services by enhancing coordination of care, eliminating duplication, and helping patients and caregivers more effectively manage health conditions.

Case Management – A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual enrollee's health-related needs through communication and available resources to promote quality and cost-effective outcomes. Case management implicitly enhances care coordination through the designation of a case manager whose specific responsibility is to oversee and coordinate access and care delivery targeted to high-risk patients with diverse combinations of health, functional, and social needs.

Case Manager – A licensed registered nurse, licensed mental health practitioner, or other trained individual who is employed or contracted by the Contractor or an enrollee's PCP. The case manager is accountable for providing intensive monitoring, follow-up, clinical management of high risk enrollees, and care coordination activities, which include development of the MCO plan of care, ensuring appropriate referrals and timely two-way transmission of useful enrollee information; obtaining reliable and timely information about services other than those provided by the PCP; supporting the enrollee in addressing social determinants of health; and supporting safe transitions in care for enrollees moving between institutional and community care settings. The case manager may serve on one or more multi-disciplinary care teams and is responsible for coordinating and facilitating meetings and other activities of those care teams.

Centers for Medicare and Medicaid Services (CMS) – The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII,

Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act. Formerly known as Health Care Financing Administration (HCFA).

CHIP – Children's Health Insurance Program created in 1997 by Title XXI of the Social Security Act. Known in Louisiana as LaCHIP.

Chisholm Class Members – All current and future Medicaid beneficiaries in the state of Louisiana under age twenty-one who are now on or will in the future be placed on the Developmental Disabilities Request for Services Registry.

Choice Counseling – Enrollment Broker activities such as answering questions and providing information in an unbiased manner on available MCOs and advising potential enrollees and enrollees on what factors to consider when choosing among them.

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.

Co-branding – A relationship between two or more separate legal entities, one of which is the Contractor, where there is joint marketing to promote enrollment with the Contractor.

Cold Call Marketing – Any unsolicited personal contact with a Medicaid eligible individual by the MCO, its staff, its volunteers or its vendors/contractors with the purpose of influencing the Medicaid eligible individual to enroll in the MCO or either to not enroll in or disenroll from another MCO.

Community Health Worker (CHW) – As defined by the American Public Health Association, frontline staff who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery for enrollees.

Continuous Quality Improvement – The process of identifying problems, implementing and monitoring corrective action and studying its effectiveness to improve health care.

Contract – The written agreement between LDH and the Contractor; comprised of the Contract, the RFP, the Contractor's RFP response which is incorporated by reference, and any addenda, appendices, attachments, or amendments thereto.

Contract Execution – The date upon which the Office of State Procurement has approved the Contract.

Contractor – Any entity that enters into an agreement with LDH for the provision of services described in this Contract.

Convicted – A formal declaration that someone was guilty of a criminal offense, made by the verdict of a jury or the decision of a judge in a court of law.

Coordinated System of Care (CSoC) – A component of the system of care for youth who have significant behavioral health challenges and who are in or at imminent risk of out-of-home placement, and their families, which is a collaborative effort among families, youth, the Department of Children and Family Services, the Department of Education, the Department of Health, and the Office of Juvenile Justice.

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

Co-payment* – Any cost sharing payment for which the enrollee is responsible, in accordance with 42 C.F.R. §447.50 and Section 5006 of the American Recovery and Reinvestment Act of 2009 (ARRA) for Native American members.

Corrective Action Period – The period of time between the acceptance by LDH of the Corrective Action Plan and the date of compliance as determined by LDH.

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

Cost Avoidance – A method of paying claims in which the provider is not reimbursed until the provider has demonstrated that all available health insurance has been exhausted.

Cost Sharing – Any co-payment, coinsurance, deductible, or other similar charge as per 42 C.F.R. §447.50-57.

Covered Drug List – A list maintained by the Contractor giving details of generic and name brand medications payable by the Contractor. The Covered Drug List shall include all outpatient drugs for which the manufacturer has entered into the Federal rebate agreement with CMS that meets the standards in Section 1927 of the Social Security Act.

Covered Services – See MCO Covered Services.

Crisis Mitigation Services – A provider's assistance to enrollees during a crisis that provides twenty-four (24)-hour on call telephone assistance to prevent relapse or harm to self or others, to provide referral to other services, and to provide support during related crises. Referral to 911 or a hospital's emergency department alone does not constitute Crisis Mitigation Services.

Cultural Competency – A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with enrollees. This requires a willingness and ability to 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.

Deliverable – Any document, manual, file, plan, or report submitted to LDH by the Contractor to fulfill requirements of this Contract.

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

Department (LDH) – The Louisiana Department of Health, hereinafter referred to as LDH.

Developmental Disability – As defined in La. R.S. 28:451.2, means either:
(1) A severe, chronic disability of a person that:

- Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments;
- Is manifested before the person reaches age twenty-two (22);
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three (3) or more of the following areas of major life activity:
  - Self-care;
  - Receptive and expressive language;
  - Learning;
  - Mobility;
  - Self-direction;
  - Capacity for independent living; and
  - Economic self-sufficiency;
- Is not attributable solely to mental illness; and
- Reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

(2) A substantial developmental delay or specific congenital or acquired condition in a person from birth through age nine (9) which, without services and support, has a high probability of resulting in those criteria in Paragraph (1) later in life that may be considered to be a developmental disability.

Direct Marketing/Cold Call – Any unsolicited personal contact with or solicitation of a Medicaid enrollee in person, through direct mail advertising or telemarketing by an employee or agent of the Contractor for the purpose of influencing an individual to enroll with the Contractor.

Disease Management (DM) – see Chronic Care Management.

Disenrollment – The removal of an enrollee from participation in the Contractor's plan, but not necessarily from the Medicaid or LaCHIP Program.

Dispensing Fee – The professional fee which: (1) is incurred at the point of sale or service and pays for the costs in excess of the ingredient cost of a covered outpatient drug each time a covered outpatient drug is dispensed; (2) includes only pharmacy costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to an enrollee. Pharmacy costs include, but are not limited to, reasonable costs associated with a pharmacist's time in checking the computer for information about an enrollee's coverage, performing drug utilization review and preferred drug list review activities, measurement or mixing of the covered outpatient drug, filing the container, enrollee counseling,

physically providing the completed prescription to the enrollee, delivery, special packaging, and overhead associated with maintaining the facility and equipment necessary to operate the pharmacy; and (3) does not include administrative costs incurred by the State in the operation of the covered outpatient drug benefit including system costs for interfacing with pharmacies.

Documented Attempt – A bona fide, or good faith, attempt, in writing, by the Contractor to enter into a contract with a provider, made on or after the date the MCO signs the Contract with LDH, and no sooner than sixty (60) calendar days following any preceding attempt. Such attempts shall include written correspondence via certified mail that outlines contract negotiations between the parties, including rate and contract terms disclosure. If, within thirty (30) calendar days following the receipt date, the potential provider rejects the request or fails to respond either verbally or in writing, the Contractor may consider the request for inclusion in the provider network as denied by the provider. Provider responses are not limited to approval or rejection of the offer. This shall constitute one (1) attempt.

DOJ Agreement Target Population (Case 3:18-cv-00608, Middle District of Louisiana) – (a) Medicaid-eligible individuals over age 18 with SMI currently residing in nursing facilities; (b) individuals over age 18 with SMI who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility placement during the course of this Agreement, or have been referred within two years prior to the effective date of this Agreement; and (c) excludes those individuals with co-occurring SMI and dementia, where dementia is the primary diagnosis.

Dual Diagnosis – The situation in which the same person is diagnosed with more than one condition, such as psychiatric disorders, neurodevelopmental disorders, substance-related and addictive disorders.

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

Durable Medical Equipment*, Prosthetics, Orthotics and certain Supplies (DMEPOS) – DME is inclusive of equipment which 1) can withstand repeated use, 2) is primarily and customarily used to serve a medical purpose, 3) generally is not useful to a person in the absence of illness or injury, and 4) is appropriate for use in the home. POS is inclusive of prosthetics, orthotics and certain supplies. Certain supplies are those medical supplies that are of an expendable nature, such as catheters and diapers.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – All medically necessary Section 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT-eligible beneficiaries ages birth to twenty-one, in accordance with 42 U.S.C. §1396d(r). This includes but is not limited to, conditions which are discovered through EPSDT Well Child screening services, whether or not such services are covered under the Medicaid State Plan. [42 U.S.C. §1396d(r)(5) and the CMS State Medicaid Manual.]

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

Emergency Dental Services – Emergency dental coverage is limited to the emergency treatment of injury to natural teeth. Treatment includes but is not limited to x-rays and emergency oral surgery to temporarily stabilize the enrollee. Dental services provided for the routine care, treatment, or replacement of teeth or structures are not covered under this Contract.

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

Emergency Medical Transportation* – Transportation provided for an emergency medical condition.

Emergency Room Care* – Emergency services provided in an emergency department.

Emergency Services* – In accordance with 42 U.S.C. §1395dd(e), §1396u-2(b)(2) and 42 C.F.R. §438.114(a), covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under Title 42 of the Code of Federal Regulations and Title XIX of the Social Security Act and that are needed to screen, evaluate, and stabilize an emergency medical condition. If an emergency medical condition exists, the Contractor is obligated to pay for the emergency service. Coverage of emergency services must not include any prior authorization requirements and the "prudent layperson" standard shall apply to both in-network and out-of-network coverage.

Encounter – A distinct set of health care services provided to an enrollee on the dates that the services were delivered.

Encounter Data – Health care encounter data include: (i) All data captured during the course of a single health care encounter that specify the diagnoses, 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 health care services during the single encounter; and (iii) a unique, unduplicated, identifier for the single encounter.

Encounter Data Adjustment – Adjustments to encounter data that are allowable under the Medicaid Management Information System (MMIS) as specified in the **MCO Manual**.

Enrollee – Louisiana Medicaid or CHIP beneficiary who is currently enrolled with the MCO, either by choice or assignment by the enrollment broker. A Medicaid beneficiary shall be considered an enrollee beginning on the effective date of enrollment with the MCO. The enrollee may be entitled to retroactive coverage.

Enrollees with Special Health Care Needs – Individuals of any age with a behavioral health disability, physical disability, developmental disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized care approaches. Enrollees with Special Health Care Needs shall include any enrollees who:

- have complex needs such as multiple chronic conditions, co-morbidities, and co-existing functional impairments;
- are at high risk for admission/readmission to a hospital within the next six (6) months;
- are at high risk of institutionalization;
- have been diagnosed with a Serious Emotional Disturbance, a Severe and Persistent Mental Illness, or a Substance Use Disorder, or otherwise have significant behavioral health needs;
- are homeless as defined in Section 330(h)(5)(A) of the Public Health Services Act and codified by

the US Department of Health and Human Services in 42 U.S.C. 254(b);
- are women with high-risk pregnancies;
- have been recently incarcerated and are transitioning out of custody;
- are at high risk of inpatient admission or Emergency Department visits, including certain enrollees transitioning care across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting;
- are members of the DOJ Agreement Target Population; or
- receive care from other state agency programs, including but not limited to programs through OJJ, DCFS, or OPH.

Enrollment – The process conducted by the enrollment broker by which an eligible Medicaid beneficiary becomes an enrollee with the MCO.

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.

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

Excluded Populations – Medicaid beneficiaries who are excluded from MCO enrollment.

Excluded Services* – Those services which enrollees may obtain under the Louisiana Medicaid State Plan and for which the Contractor is not financially responsible.

Executive Capacity – Serving as a Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Medical Director, or a Behavioral Health Medical Director.

External Quality Review (EQR) – The analysis and evaluation by an external quality review organization of aggregated information on quality, timeliness, and access to the health care services that a Contractor or its subcontractors furnish to Medicaid enrollees.

External Quality Review Organization (EQRO) – An organization that meets the competence and independence requirements set forth in 42 C.F.R. §438.354, and performs EQR and other EQR-related activities as set forth in 42 C.F.R. §438.358, or both.

Family Planning Services – Services for men, women and adolescents that include examinations and assessments, diagnostic procedures, health education, and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics and pharmacies.

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

Federally Qualified Health Center (FQHC) – An entity that receives a grant under Section 330 of the Public Health Service Act (also see 42 U.S.C. §1396d(l)(2)(B) of the Social Security Act) to provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.

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

Fidelity – The accuracy and consistency of an intervention to ensure it is implemented as planned and that each component is delivered in a comparable manner to all members over time.

Fiscal Intermediary (FI) – LDH's contractor responsible in the current delivery model for an array of support services including MMIS development and support, claims processing, pharmacy support services, provider support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support.

For Cause – For a legitimate, specific reason; with justification.

Formulary – A list maintained by the MCO giving details of medications payable by the MCO's health plan.

Fraud – As relates to Medicaid Program Integrity, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law. Fraud may include, but is not limited to, deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received.

Full-Time Equivalent Position (FTE) – Refers to the equivalent of one (1) individual full-time employee who works forty (40) hours per week or a full-time primary care provider delivering outpatient preventive and primary (routine, urgent and acute) clinical care for twenty-four (24) hours or more per week (exclusive of travel time).

Grievance* – An expression of enrollee dissatisfaction about any matter other than an adverse benefit determination as defined in this Contract. Examples of grievances include, but are not limited to, dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

Grievance System – The manner in which enrollee grievances, appeals, and access to the State's fair hearing system are managed.

Habilitation Services and Devices* – Health care services that help enrollees keep, learn, or improve skills and functioning for daily living.

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

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

Health Disparity – The preventable differences in health outcomes in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by disadvantaged populations.

Health Equity – A state where every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.

Health Insurance* – A type of insurance coverage that pays for medical and surgical expenses incurred by the insured. Health insurance can reimburse the insured for expenses incurred from illness or injury, or pay the care provider directly.

Health Needs Assessment – A person-centered assessment of an enrollee's care needs, functional needs, accessibility needs, goals, and other characteristics.

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

HIPAA Privacy Rule (45 C.F.R. Parts 160 and 164) – Standards for the privacy of individually identifiable health information.

HIPAA Security Rule (45 C.F.R. Parts 160 and 164) – Part of the rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which require covered entities to maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their Electronic Protected Health Information against any reasonably anticipated risks.

Home and Community Based Services Waiver (HCBS) – Under 42 U.S.C. §1396n(c) of the Social Security Act, states may request waiver of the requirements relating to statewide comparability of services, and community income and resource rules for the medically needy in order to develop Medicaid-financed community-based treatment alternatives. Non-State Plan services that may be offered include case management, homemaker/home health aide services, personal care services, adult day health, habilitation, and respite care. Current HCBS waivers in Louisiana are New Opportunities Waiver (NOW), Children's Choice, Community Choices Waiver (CCW), Adult Day Health Care Waiver (ADHC), Supports Waiver, Coordinated System of Care (CSoC), and Residential Options Waiver (ROW).

Home Health Care or Services* – Patient care services provided in the patient's residential setting or any setting in which normal life activities take place under the order of a physician that are necessary for the diagnosis and treatment of the patient's illness or injury, including one or more of the following services: (1) skilled nursing; (2) physical therapy; (3) speech-language therapy; (4) occupational therapy; (5) home health aide services; or (6) medical supplies, equipment and appliances suitable for use in any setting in which normal life activities take place.

Homeless – As defined in 42 U.S.C. §254b, means, an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing. A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or any other unstable or non-permanent situation. A person may be considered to be homeless if that person is "doubled up," a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of

friends and/or extended family members. In addition, previously homeless individuals who are to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. A recognition of the instability of an individual's living arrangements is critical to the definition of homelessness (HRSA/Bureau of Primary Health Care, Program Assistance Letter 99-12).

Hospice Care or Services* – An alternative treatment approach that is based on a recognition that impending death requires a change from curative treatment to palliative care for the terminally ill patient and supporting family. Palliative care focuses on comfort care and the alleviation of physical, emotional and spiritual suffering. Instead of hospitalization, its focus is on maintaining the terminally ill patient at home with minimal disruptions in normal activities and with as much physical and emotional comfort as possible.

Hospital Outpatient Care* – Care in a hospital that usually doesn't require an overnight stay.

Hospitalization* – Admission to a hospital for treatment.

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. MCOs shall transition to newer versions as they become effective.

Immediate – In an immediate manner; instant; instantly or without delay, but not more than twenty-four (24) hours.

In Lieu of Service (ILOS) – A medically-appropriate service outside of MCO covered services or settings (or beyond service limits established by LDH for MCO covered services) that are provided to enrollees, at their option, by the Contractor as a cost-effective alternative to an MCO covered service or setting.

Incentive Arrangement – Any payment mechanism under which a Contractor or subcontractor may receive additional funds over and above the rate it was paid for meeting targets specified in the contract.

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

Indian – Includes an Indian, as defined in 25 U.S.C. §1603 (13), an Urban Indian, as defined in 25 U.S.C. §1603 (28), a California Indian, as defined in 25 U.S.C. §1679(a) or an individual who has been determined eligible as an Indian, under 42 C.F.R. § 136.12.

Indian Health Care Provider (IHCP) – A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in §4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Individuals with Disabilities Education Act (IDEA) – A United States federal law that ensures services to children with disabilities throughout the United States. IDEA governs how states and public agencies provide early intervention, special education and related services to children with disabilities.

Information Systems (IS) – A combination of computing hardware and software that is used in: (a) the

capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.

Insolvency – A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets, or as determined by the Louisiana Department of Insurance pursuant to Title 22 of the Louisiana Revised Statutes of 1950.

Intellectual Disability – A type of developmental disability, formerly known as mental retardation, characterized by significantly impaired intellectual and adaptive functioning. It is defined by an IQ score under 70 in addition to deficits in two (2) or more adaptive behaviors that affect every day, general living. A diagnosis of intellectual disability alone does not constitute eligibility for Developmental Disabilities services.

Interdisciplinary Team – A group that reviews information, data, and input from a person to make recommendations relevant to the needs of the person. The team consists of the person, his legal Representative if applicable, professionals of varied disciplines who have knowledge relevant to the person's needs, and may include his family enrollees along with others the person has designated.

Intermediate Care Facility for Individuals with Developmental Disabilities (ICF/DD) – A facility licensed by the Louisiana Department of Health (LDH) Health Standards Section (HSS) to provide residential care for four (4) or more individuals that meet the criteria for twenty-four (24) hours per day of Active Treatment. ICF/DD facilities are considered “institutions” and not Home and Community Based Services by CMS.

Intermediate Sanctions – Those actions authorized by 42 C.F.R. Part 438, Subpart I for certain actions or omissions by a MCO.

Investigational Procedure/Service – See Experimental Procedure/Service.

Kick Payment – The method of reimbursing a Contractor in the form of a separate one (1) time fixed payment for specific services in addition to the PMPM payment.

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

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

Legend Drugs – Drugs which bear the federal legend: “Caution: federal law prohibits dispensing without a prescription.”

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

- Medical Psychologists
- Licensed Psychologists
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Counselors (LPCs)
- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Addiction Counselors (LACs)
- Advanced Practice Registered Nurses (APRN) (must be a nurse practitioner specialist in Adult Psychiatric & Mental Health, and Family Psychiatric & Mental Health or a Certified Nurse Specialists in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health and may practice to the extent that services are within the APRN's scope of practice)

Liquidated Damages – Damages that may be assessed whenever a Contractor, its providers, and/or its subcontractors fail to achieve certain performance standards and other items defined in the terms and conditions of the Contract.

Local Governing Entity (LGE) – One of several independent regional health care districts and authorities located throughout the State. Within the jurisdiction of LGEs, services are provided through various arrangements including state operated, state contracted services, private comprehensive providers, rehabilitation agencies, community addiction and mental health clinics, LMHPs, and certified peer support specialists.

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

Louisiana's Health Insurance Premium Payment Program (LaHIPP) – Louisiana Medicaid program that pays for some or all of the health insurance premiums for an employee and their family if they have insurance available through their job and someone in the family is enrolled in Medicaid.

Louisiana Medicaid State Plan – The binding written agreement between LDH and CMS which describes how the Medicaid program is administered by LDH and determines the services for which LDH will receive federal financial participation.

Managed Care Organization (MCO) – A private entity that meets the mandatory business requirements of the RFP and contracts with LDH to provide covered services to Louisiana Medicaid managed care program enrollees in exchange for a monthly prepaid capitated amount per enrollee. The entity must have an active license or certificate of authority issued by the Louisiana Department of Insurance which regulates the MCO with respect to licensure and financial solvency, pursuant to La. R.S. 22:1016, but shall, solely with respect to its products and services offered pursuant to the Louisiana Medicaid Program be regulated by the Louisiana Department of Health.

Managed Care Program – Louisiana Medicaid program providing Medicaid covered services to enrollees through select MCOs with the goal of effectively utilizing resources to promote the health and well-being of Louisianans.

Mandatory MCO Population – The groups of Medicaid beneficiaries who are required to enroll with an MCO and whose participation is not voluntary.

Marketing – Any communication from a Contractor to a Medicaid enrollee or potential enrollee that can reasonably be interpreted as intended to influence the enrollee's choice of MCO.

Marketing Materials – Information produced in any medium, by or on behalf of an MCO that can reasonably be interpreted as intended to market to potential enrollees or enrollees**.**

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

Material Changes – Material changes are changes affecting the delivery of care or services provided under this Contract. Material changes include, but are not limited to, changes in composition of the provider network, subcontractor, or subcontractor's network, the Contractor's complaint and grievance procedures; health care delivery systems, services, changes to proposed value-added benefits or services; enrollment of a new population; procedures for obtaining access to or approval for health care services; any and all policies and procedures that require LDH approval prior to implementation; and the Contractor's capacity to meet minimum enrollment levels. LDH shall make the final determination as to whether a change is material.

Material Subcontract – Any contract or agreement by which the Contractor procures, re-procures, or proposes to subcontract with, for the provision of all, or part, of any program area or function that relates to the delivery or payment of MCO covered services including, but not limited to, behavioral health, claims processing, care management, utilization management, transportation, or pharmacy benefits, including specialty pharmacy providers.

May – A term that denotes a permissible action.

MCO Covered Services – Those Medicaid covered health care benefits and services that are required to be provided by the Contractor to Medicaid enrollees as specified in Attachment A of the Contract. (In lieu of services and value-added benefits are described in Attachments B and C.)

MCO Manual – A compilation of policies, instructions, and guidelines established by LDH for the administration of the Louisiana Medicaid managed care program.

MCO Plan of Care – The plan developed by the MCO in conjunction with the enrollee and other individuals involved in the enrollee's case management to support the coordination of an enrollee's care and provide support to the enrollee in achieving care goals.

Measurable – Applies to a Contractor objective and means the ability to determine definitively whether

or not the objective has been met, or whether progress has been made toward a positive outcome.

Measurement Year – With regard to health care quality measure reporting, measurement year refers to the timeframe during which health care services are provided. For example, for most HEDIS® measures, the previous calendar year is the standard measurement year. The health care quality measure steward defines the measurement year (or period) in the technical specifications for each measure.

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

Medicaid Covered Services – Those health care services to which an eligible Medicaid beneficiary is entitled under the Louisiana Medicaid State Plan.

Medicaid Eligibility Office – LDH offices located within select parishes of the state and centralized State Office operations that are responsible for initial and ongoing Medicaid financial eligibility determinations.

Medicaid Management Information System (MMIS) – Mechanized claims processing and information retrieval system used to process claims for Medicaid payment and includes information on all Medicaid providers and enrollees.

Medicaid Provider* – Any Medicaid service provider contracted with a health plan and/or enrolled in the Medicaid Program.

Medical Director/Chief Medical Officer – The licensed physician designated by the Contractor to exercise general supervision over the provision of MCO covered services.

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

Medical Loss Ratio – The percentage of PMPM payments received by the Contractor from LDH used to pay medical claims from providers and approved quality improvement and health information technology 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 health care services whether provided by the MCO, its subcontractor, or any out-of-network providers. The records may be electronic, paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 C.F.R §456.111 and §456.211.

Medically Necessary Services* – Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical

deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the beneficiary. 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 beneficiary requires at that specific point in time. 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."

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

Member Materials – All written materials produced or authorized by the Contractor and distributed to enrollees or potential enrollees containing information concerning the MCO. Member materials include, but are not limited to, member ID cards, member handbooks, provider directories, and marketing materials.

Member Month – A month of coverage for a Medicaid enrollee.

Mental Health/Substance Use (MH/SU) Providers – Behavioral health professionals engaged in the treatment of substance use, dependency, addiction, or mental illness.

Monetary Penalty – Financial assessment that may be enforced whenever a Contractor and/or its subcontractors fail to meet the requirements of this Contract.

Must – Denotes a mandatory requirement.

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

Network* – The collective group of providers who have entered into provider agreements with the Contractor for the delivery of MCO covered services. This includes, but is not limited to physical, behavioral, pharmacy and ancillary service providers. Also referred to as Provider Network.

Network Adequacy – Refers to the network of health care providers for an MCO that is sufficient in numbers and types of providers and facilities to ensure that all services are accessible to 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. Network Adequacy will be assessed on the MCOs contracted network providers excluding single case agreements unless otherwise approved by LDH.

Network Provider or Provider* – An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors that has a provider agreement with the Contractor for the delivery of MCO covered services to the Contractor's enrollees.

Network Provider Agreement – A contract between the Contractor and a network provider for the

delivery of MCO covered services to enrollees, including any in lieu of services offered by the Contractor.

Newborn – A live infant born to a Contractor's enrollee.

Non-Emergency Medical Transportation (NEMT) – A ride, or reimbursement for a ride, provided so that an enrollee with no other transportation resources can receive services from an entity providing MCO covered services. NEMT does not include transportation provided on an emergency basis, such as trips to the ED in life threatening situations.

Non-Emergency Services – Services provided to an enrollee who has presentation of medical signs and symptoms to a health care provider.

Non-Participating Provider* – A provider that does not have a signed network provider agreement with the Contractor.

Non-Urgent Sick Care – Medical care given for an acute onset of symptoms that is not emergent or urgent in nature. Examples of non-urgent conditions include cold symptoms, sore throat, and nasal congestion.

Nurse Practitioner (NP) – An advanced practice registered nurse educated in a specified area of care and certified according to the requirements of a nationally recognized accrediting agency such as the American Nurses Association's American Nurses Credentialing Center, National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties, or the National Certification Board of Pediatric Nurse Practitioners and Nurses, or as approved by the Louisiana State Board of Nursing and who is authorized to provide primary, acute, or chronic care, as an advanced nurse practitioner acting within his/her scope of practice to individuals, families, and other groups in a variety of settings including, but not limited to, homes, institutions, offices, industry, schools, and other community agencies.

OCDD Statement of Approval – A document received by individuals who have completed the System Entry process at one of the ten (10) Human Service Districts/Authorities (also called the Local Governing Entity or LGE). This document indicates that the individual meets the legal definition of Intellectual/Developmental Disability as defined by La. R.S. 28:451.2. This document further indicates the individual meets the criteria to receive services from the Developmental Disability service system.

Open Enrollment – The period of time when an enrollee may change MCOs without cause (once per year after initial enrollment).

Open Panel – PCPs who are accepting new patients for the Contractor.

Operational Start Date – The first date on which the Contractor is responsible for providing MCO covered services to their enrollees and is responsible for compliance with all aspects of the Contract. This date is at the discretion of LDH, but is anticipated to be January 1, 2020. The Operational Start Date may be delayed by LDH for one or more MCOs depending on readiness review results.

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

Outlier – Additional payment that is made for catastrophic costs associated with services provided to 1)

children under the age of six who received inpatient services in a disproportionate share hospital setting, and 2) infants who have not attained the age of one year who received inpatient services in any acute care setting.

Ownership Interest – The possession of stock, equity in the capital, or any interest in the profits of the Contractor; for further definition see 42 C.F.R. §455.101.

Participating Provider* – A provider that has a signed network provider agreement with a MCO.

Patient-Centered Medical Home (PCMH) – A system of care led by a team of primary care providers who partner with the patient, the patient's family and the community to coordinate care in all settings, from specialists and hospitals to pharmacies, mental health programs, and home health agencies.

Peer Specialist – A paraprofessional with specialized training who has a personal experience in special health care needs and chronic or complex illness and who engages with enrollees, providing person-centered, culturally sensitive support building on the values, strengths and preferences of the enrollee.

Pended Claim – A claim for which additional information is being requested in order for the claim to be adjudicated.

Performance Improvement Projects (PIP) – Projects designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction.

Performance Measures – Tools that quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.

Permanent Supportive Housing (PSH) – Consists of deeply affordable, community-integrated rental housing combined with supportive services that are designed to assist households in gaining and maintaining access to safe, good quality housing. In PSH, the service beneficiary is the tenant and lessee. Tenancy is not contingent upon continued receipt of services.

Permanent Supportive Housing Program – The Louisiana PSH program is a cross-disability program that provides rental subsidies for over 3,300 affordable housing units statewide to low income enrollees with substantial, long-term disabilities. In Louisiana, PSH services are reimbursed under several Medicaid HCBS programs, and under specialized behavioral health State Plan services where it is billed as a component of CPST and PSR. To be eligible for PSH, Medicaid Managed Care enrollees must meet PSH program eligibility criteria and medical necessity criteria for services. Overall management of the PSH program is centralized within LDH and final approval for enrollees to participate in PSH is made by the LDH PSH program staff.

Person-centered – A care planning process driven by the enrollee that identifies supports and services that are necessary to meet the enrollee's needs in the most integrated setting. The enrollee directs the process to the maximum extent possible and is provided sufficient information and support to make informed choices and decisions. The process is timely and occurs at times and locations convenient to the enrollee, reflects the cultural and linguistic considerations of the enrollee, provides information in plain language and in a manner that is accessible to enrollees, and includes strategies for resolving conflict or

disagreement that arises in the planning process.

Personal Care Services (PCS) – Provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing, and personal hygiene. Does not include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters.

Pharmacy Benefits Manager (PBM) – A third party administrator of prescription drug programs.

Physician Services* – The services provided by an individual licensed under state law to practice medicine or osteopathy. It does not include services that are offered by doctors while admitted in the hospital, and charges for which are included in the hospital bill.

Plan* – An individual or group that provides, or pays the cost of, medical care.

Population Health – The health outcomes of the Contractor's enrollee population, including the distribution of such outcomes within the group. It is an approach aimed at improving the health of the enrollee population as a whole.

Post-Stabilization Care Services – Medicaid covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain, improve or resolve the enrollee's condition pursuant to 42 C.F.R. §438.114.

Potential Enrollee – A Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in an MCO, but is not yet an enrollee of a specific MCO.

Pre-Admission Screening and Resident Review (PASRR) – Pre-Admission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long-term care. PASRR requires that all applicants to a Medicaid-certified nursing facility (1) be evaluated for mental illness and/or intellectual disability; (2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and (3) receive the services they need in those settings.

Preferred Drug List (PDL) – A list maintained by the Contractor indicating which drugs providers are permitted to prescribe without seeking prior authorization or a prior authorization to review clinical criteria.

Premium* – An amount to be paid for an insurance policy.

Prescription Drugs* – A drug that can be obtained only by means of a prescription.

Prescription Drug Coverage* – Health insurance or plan that helps enrollees pay for prescription drugs and medications.

Preventive Care – Refers to the treatment to avert disease/illness and/or its consequences. The term is used to designate prevention and early detection programs rather than restorative or treatment programs. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred.

Primary Care Physician or Provider (PCP)* – An individual physician, nurse practitioner, or physician assistant who accepts primary responsibility for the management of an enrollee's health care. The primary care provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care), or admit the patient to a hospital.

Primary Care Services – Health care services and laboratory services customarily furnished by or through a PCP for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion either 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.

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

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

Provider Appeal – The formal mechanism which allows a provider the right to appeal an MCO final decision.

Provider-beneficiary Relationship – A relationship that is defined as one in which the provider is the main source of Medicaid services for the beneficiary during the past twelve (12) months based on claims data sorted by the most frequently visited PCP.

Provider Complaint – A verbal or written expression by a provider which indicates dissatisfaction or dispute with MCO policy, procedure, claims processing and/or payment, or any aspect of the Contractor's functions.

Provider Directory – A listing of health care service providers within the Contractor's provider network that is prepared by the MCO as a reference tool to assist enrollees in locating providers that are available to provide services.

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

Provider Agreement – An agreement between the Contractor and a provider to furnish covered services to enrollees.

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

Quality – As it pertains to external quality review, means the degree to which a Contractor increases the

likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Assessment and Performance Improvement (QAPI) Plan – A written plan detailing the Contractor's quality management and committee structure, performance measures, monitoring and evaluation process, and improvement activities measures that rely upon quality monitoring implemented to improve health care outcomes for enrollees.

Quality Assessment and Performance Improvement Program (QAPI Program) – Program that objectively and systematically defines, monitors and evaluates the quality and appropriateness of care and services, and promotes improved patient outcomes through performance improvement projects, medical record audits, performance measures, surveys, and related activities.

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

Readiness Review – Refers to LDH's assessment of the Contractor's ability to fulfill the Contract requirements. Such review may include, but is not be limited to, review of proper licensure, operational protocols, review of MCO standards, and review of systems. The review may be done as a desk review, on-site review, or combination and may include interviews with pertinent personnel so that LDH can make an informed assessment of the Contractor's ability and readiness to render services.

Re-admission – Subsequent admissions of a patient to a hospital or other health care institution for treatment.

Recovery (In reference to behavioral health services) – A process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Referral Services – Health care services provided to enrollees to both in- and out-of-network providers when ordered and approved by the Contractor, including, but not limited to in-network specialty care and out-of-network services which are covered under the Louisiana Medicaid State Plan.

Registered Nurse (RN) – Person licensed as a Registered Nurse by the Louisiana State Board of Nursing.

Rehabilitation Services and Devices* – Services ordered by the enrollee's PCP to help the enrollee recover from an illness or injury. These services are provided by nurses and physical, occupational, and speech therapists.

Reinsurance – Insurance a Contractor purchases to protect itself against part or all of the losses which may be incurred in the process of honoring the claims of enrollees; also referred to as "stop loss" insurance coverage.

Rejected Claim – A claim that does not pass standard, front-end HIPAA edits, indicating that there is missing or invalid data such that there is insufficient information to process the claim.

Remittance Advice – An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only.

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 beneficiary. This is the same individual who completes and signs the Medicaid application on behalf of a covered individual, agreeing to the rights and responsibilities associated with Medicaid coverage.

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

Risk – The chance or possibility of loss associated with provision of care for a given population.

Risk Adjustment – A method for determining adjustments to the PMPM rate that accounts for variation in health risks among participating MCOs when determining capitation payments.

Routine Care – Treatment of a condition which would have no adverse effects if not treated within 24 hours or that could be treated in a less acute setting (e.g., physician's office) or by the patient.

Routine Primary Care – Routine primary care services include the diagnosis and treatment of conditions to prevent deterioration to a more severe level, or minimize/reduce risk of development of chronic illness or the need for more complex treatment. Examples include psoriasis, chronic low back pain; requires a face-to-face visit within four (4) weeks of enrollee request.

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

Rural Hospital – Hospital licensed by LDH which meets the definition in La. R.S. 40:1189.3.

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

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

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

Service Area – The designated area in which the Contractor is authorized to furnish covered services to enrollees. The service area is the entire state of Louisiana.

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

Shall – A term that denotes a mandatory requirement.

Should – A term that denotes a desirable action.

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

Skilled Nursing Care* – A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).

Social Determinants of Health (SDOH) – The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.

Social Security Act – The Social Security Act of 1935, as amended, 42 U.S.C. §301-1397mm provides for the Medicaid Program (Title XIX) and CHIP Program (Title XXI).

Solvency – The minimum standard of financial health for a Contractor where assets exceed liabilities and timely payment requirements can be met.

Span of Control – Information systems and telecommunications capabilities that the Contractor 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 Contractor.

Specialist* – A specialist/subspecialist is a health care professional who is not a primary care physician.

Specialized Behavioral Health Services – Mental health services and substance use services that are provided outside of primary care, unless furnished in an integrated care setting, and include, but are not limited to, services provided by a psychiatrist, LMHP, and/or mental health rehabilitation provider.

Stabilized – With respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to a woman in labor, the woman has delivered (including the placenta).

State – The State of Louisiana.

State Plan – Refers to the Louisiana Medicaid State Plan.

Sterilization – Any medical treatment or procedure that renders an individual permanently incapable of reproducing.

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

Subcontractor – A person, agency or organization with which the Contractor has subcontracted or delegated some of its management functions or other contractual responsibilities to provide MCO 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.

Substantial Contractual Relationship – Any direct or indirect business transactions that amount within a twelve (12) month period to more than twenty-five thousand dollars ($25,000) or five percent (5%) of the Contractor's total operating expenses, whichever is less.

Supplemental Security Income (SSI) – A federal program which provides a cash benefit to people who are aged, blind or disabled and who have little or no income or assets. Louisiana is a "Section 1634" state and anyone determined eligible for SSI is automatically eligible for Medicaid, in accordance with 42 U.S.C. §1383c.

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

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

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

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

Targeted Case Management – Case management for a targeted population of persons with special needs described in the Louisiana Medicaid State Plan.

Telemedicine – Provision of MCO covered services through two-way, real time interactive communication between the patient and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

Tenancy Supports – Supports provided under CPST and PSR to that subset of enrollees accepted for participation in Louisiana's Permanent Supportive Housing program. Tenancy and pre-tenancy supports are designed to help enrollees access and maintain successful tenancy in the community-integrated,

affordable housing provided through Louisiana's PSH program. Tenancy and pre-tenancy supports consist of activities such as helping enrollees complete apartment applications, seek reasonable accommodation, negotiate and enter into leases, understand the role of tenant, understand tenant rights, develop budgets, make timely rent payments, comply with terms of lease, adjust to new home and neighborhood (including how to get to and access essential services), apply for income benefits such as SSI, comply with medication and other treatment regimes, and develop/implement crisis plans to avoid eviction.

Tertiary Care – Highly specialized medical care, usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities.

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

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

Title IV-E – Means Title IV, Part E, of the Social Security Act, 42 U.S.C. §§670-679c, which provides for medical assistance for foster children and adoption assistance.

Title V – Means Title V of the Social Security Act, 42 U.S.C. §§701-713, which provides for maternal and child health services. Federal laws and regulations mandate cooperation between state agencies responsible for the administration and supervision of both Title V and Title XIX of the Social Security Act.

Title X – Means Title X of the Public Health Services Act, 42 U.S.C. §§§300-300a-6, which provides for family planning services.

Title XIX – Means Title XIX of the Social Security Act, 42 U.S.C. §§1396-1396w-5, which authorizes and governs the Medicaid Program.

Title XXI – Means Title XXI of the Social Security Act, 42 U.S.C. §§1397aa-1397mm, which authorizes and governs the Children's Health Insurance Program (CHIP).

Total Cost of Care (TCOC) – A broad indicator of spending for a given population (i.e., payments from payer to provider organizations). In the context of population-based payment models, TCOC includes spending associated with caring for a defined population, typically including all provider and facility fees, inpatient and ambulatory care, pharmacy, behavioral health, laboratory, imaging, and other ancillary services.

Transition Phase – Includes all activities the MCO is required to perform between the date the Contract is signed by all parties and the operational start date as defined in this Contract and the **MCO Manual**.

Transitional Case Management – The evaluation of an enrollee's medical care needs and coordination of any other support services in order to arrange for safe and appropriate care after discharge from one level of care to another level of care, including referral to appropriate services.

Treatment Planning – An administrative treatment planning activity provided under Medicaid requirements at 42 C.F.R. §438.208(c) for developing and facilitating implementation of individualized

plans of care for enrollees with special health care needs and other enrollees as required under federal law. Treatment planning is provided to address the unique needs of clients living in the community and does not duplicate any other Medicaid State Plan service or services otherwise available to the beneficiary at no cost.

Turnover Phase – Includes all activities the Contractor is required to perform in conjunction with the end of the Contract.

Turnover Plan – The written plan developed by the Contractor, approved by LDH, to be employed during the turnover phase.

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 functions, or cause the development of a chronic illness or need for a more complex treatment. Examples of conditions that require urgent care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, and suspected fracture. Urgent care requires timely face-to-face medical attention within 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 time.

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

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

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

Value-Added Benefit – The additional benefits outside of the MCO covered services that are delivered at the Contractor's discretion and are not included in MCO capitation rate calculations. Value-added benefits do not include in lieu of services.

Value-Based Payment (VBP) – Broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures of quality and/or cost or resource use.

Voluntary Population – Refers to categories of individuals eligible for, and enrolled in Louisiana Medicaid who are not mandated to enroll in an MCO. By default, they will be included in the MCO program if they do not opt out during the thirty (30) day choice period.

Waiver – A binding written agreement between LDH and CMS that describes approved exceptions to the State Plan and additional State assurances regarding how the Medicaid program is administered by LDH (including LDH-contracted MCOs where applicable). Waivers may include, but are not limited to, Section 1915(c) Home and Community Based Services Waivers, Section 1915(b) Managed Care Waivers, and Section 1115 Demonstration Waivers.

WIC (Women, Infants and Children) – Federal program administered by the Office of Public Health that provides nutritional counseling; nutritional education; breast-feeding promotion; and nutritious foods to pregnant, postpartum and breast-feeding women and infants and children up to the age of five (5) who are determined to be at nutritional risk and who have a low to moderate income. An individual who is eligible for Medicaid is automatically income eligible for WIC benefits.

Week – The entire seven (7) day week, Monday through Sunday.

Will – A term that denotes a mandatory requirement.

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

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

1.2 Acronyms

ACD – Automated Call Distribution

ACE – Adverse Childhood Experience

ACH – Automated Clearinghouse

ACT – Assertive Community Treatment

ADA – Americans with Disabilities Act

ADHC – Adult Day Health Care

ADT—Admit Discharge Transfer

AFDC – Aid to Families with Dependent Children

APM – Alternative Payment Model

APRN - Advanced Practice Registered Nurse

ARRA—American Recovery and Reinvestment Act

ASAM – American Society of Addiction Medicine

ASC – Accredited Standards Committee

ASL—American Sign Language

BCC – Breast and/or Cervical Cancer

BCP – Business Continuity Plan

BHSF – Bureau of Health Services Financing

CAHPS – The Consumer Assessment of Health Providers and Systems

CANS – Child and Adolescent Needs and Strengths

CAP – Corrective Action Plan

CAQH -- Council for Affordable Quality Healthcare

CARF -- Commission on Accreditation of Rehabilitation Facilities

CC – Children's Choice

CCW – Community Choices Waiver

CDC – Centers for Disease Control and Prevention

CEHRT—Certified Electronic Health Record Technology

CEO—Chief Executive Officer

C.F.R. – Code of Federal Regulations

CHAMP – Child Health and Maternal Program

CHIP – Children's Health Insurance Program

CHW – Community Health Worker

CI – Crisis Intervention

CLAS – Culturally and Linguistically Appropriate Services

CLIA – Clinical Laboratory Improvement Amendments

CMO – Chief Medical Officer

CMS – Centers for Medicare and Medicaid Services

COA – Council on Accreditation

COB – Coordination of Benefits

COLA – Cost of Living Adjustment

CON – Certification of Need

COO – Chief Operating Officer

CPST – Community Psychiatric Support and Treatment

CPT – Current Procedural Terminology

CQI – Continuous Quality Improvement

CSoC – Coordinated System of Care

CVO – Credentials Verification Organization

CY – Calendar Year

DCFS – Department of Children and Family Services

DD – Developmentally Disabled

DHHS – Department of Health and Humans Services (also HHS)

DME – Durable Medical Equipment

DOE – Department of Education

DOI – Louisiana Department of Insurance

DOS – Date(s) of Service

DRA – Deficit Reduction Act

DRP – Disaster Recovery Plan

DSA – Data Sharing Agreement

DSH – Disproportionate Share Hospital

DUR – Drug Utilization Review

EB – Enrollment Broker

EBP – Evidenced Based Practices

ED – Emergency Department

EDI – Electronic Data Interchange

EFT – Electronic Funds Transfer

EHR – Electronic Health Records

EOB – Explanation of Benefits

EPO – Exclusive Provider Organizations

EPSDT – Early and Periodic Screening, Diagnosis and Treatment

EQR – External Quality Review

EQRO – External Quality Review Organization

ER – Emergency Room

FDA – Food and Drug Administration

FFP – Federal Financial Participation

FFS – Fee-for-Service

FFT – Functional Family Therapy

FI – Fiscal Intermediary

FITAP – Family Independence Temporary Assistance Program

FMP – Full Medicaid Pricing

FNS – Facility Notification System

FOC – Freedom of Choice

FQHC – Federally Qualified Health Center

FSO – Family Support Organization

FTE – Full-Time Equivalent

FTP – File Transfer Protocol

GAO – Government Accountability Office

GME – Graduate Medical Education

GPRA – Government Performance Reporting and Results Act

HACTA – Homebuilders Assertive Community Treatment Act

HCBS – Home and Community Based Services Waiver

HCFA – Health Care Financing Administration

HCP-LAN – Health Care Payment Learning and Action Network

HEDIS – Healthcare Effectiveness Data and Information Set

HHS – United States Department of Health and Human Services

HIE – Health Information Exchange

HIPAA – Health Insurance Portability and Accountability Act

HIPDB – Health Integrity Protection Data Bank

HIPF – Health Insurance Provider Fee

HITECH – Health Information Technology for Economic and Clinical Health Act

HNA – Health Needs Assessment

HPE – Hospital Presumptive Eligibility

HPSA – Health Professional Shortage Area

HRSA – Health Resources and Services Administration

HSIC – Human Services Interagency Council

HSS – Health Standards Section

IB – Incentive-based

ICF/DD – Intermediate Care Facility for the Developmentally Disabled

ICN – Internal Control Number

I/DD – Intellectual/Developmental Disability

ID – Identification

IDEA – Individuals with Disabilities Education Act

IEP – Individualized Education Plan

IHCP – Indian Health Care Provider

IHS – Indian Health Service

IMD – Institution for Mental Diseases

IRS – Internal Revenue Service

IS – Information Systems

ISA – Interoperability Standards Advisory

ISCA – Information Systems Capabilities Assessment

IVR – Interactive Voice Response

IV&V – Independent Verification and Validation

JLCB – Joint Legislative Committee on the Budget

LAALS – Louisiana Adverse Actions List Search

LAC – Licensed Addiction Counselor

LaCHIP – Louisiana Children's Health Insurance Program

LaHIPP – Louisiana Health Insurance Premium Payment Program

LCSW – Licensed Clinical Social Worker

LDH – Louisiana Department of Health

LDOE – Louisiana Department of Education

LEERS – Louisiana Electronic Event Registration System

LEIE – List of Excluded Individuals/Entities

LGE – Local Governing Entity

LHA – Louisiana Housing Authority

LIFC – Low Income Families and Children

LLA – Louisiana Legislative Auditor

LMFT – Licensed Marriage and Family Therapists

LMHP – Licensed Mental Health Professional

LPC – Licensed Professional Counselors

LOCUS – Level of Care Utilization System

LTC – Long Term Care

LTSS – Long-Term Supports and Services

MAC – Maximum Allowable Cost

MAT – Medication Assisted Treatment

MCIP – Managed Care Incentive Program

MCO – Managed Care Organization

MEF – Medicaid Exclusion File

MFCU – Medicaid Fraud Control Unit

MH/SU – Mental Health/Substance Use

MHR – Mental Health Rehabilitation

MIS – Management Information System

MLR – Medical Loss Ratio

MMIS – Medicaid Management Information System

MOU – Memorandum of Understanding

MST – Multi-Systemic Therapy

MVA – Medical Vendor Administration

NCCI – National Correct Coding Initiative

NCQA – National Committee for Quality Assurance

NDC – National Drug Code

NEAT – Non-Emergency Ambulance Transportation

NEMT – Non-Emergency Medical Transportation

NF – Nursing Facility

NICU – Neonatal Intensive Care Unit

NIST – National Institute of Standards and Technology

NMP – Notice of Monetary Penalty

NOA – Notice of Action

NOMS – National Outcome Measures

NOW – New Opportunities Waiver

NP – Nurse Practitioner

NPI – National Provider Identifier

NQTL – Nonquantitative Treatment Limitations

OCDD – Office for Citizens with Developmental Disabilities

OCR – Optical Character Recognition

ODBC – Open Database Connectivity

OEM – Original Equipment Manufacturer

OIG – Office of Inspector General

OJJ – Office of Juvenile Justice

OLE – Object Linking and Embedding

OMH – Office of Minority Health

ONC – Office of the National Coordinator

OON – Out-of-Network

OPH – Office of Public Health

PA – Prior Authorization

PACE – Program of All-Inclusive Care for the Elderly

PASRR – Pre-Admission Screening and Resident Review

PBM – Pharmacy Benefits Manager

PCMH – Patient-Centered Medical Home

PCN – Processor Control Number

PCP – Primary Care Provider

PCS – Personal Care Services

PDL – Preferred Drug List

PHI – Protected Health Information

PIP – Performance Improvement Projects

PMPM – Per Member, Per Month

POC – Plan of Care

POS – Point of Sale

PPACA – Patient Protection and Affordable Care Act

PPS – Prospective Payment System

PRTF – Psychiatric Residential Treatment Facilities

PSH – Permanent Supportive Housing

PSR – Psychosocial Rehabilitation

PT – Physical Therapy

QA – Quality Assurance

QAPI – Quality Assessment and Performance Improvement Plan

QDWI – Qualified Disabled Working Individual

QI – Quality Improvement

QI-1 – Qualifying Individual

QM – Quality Management

QMB – Qualified Medicare Beneficiary

QM/QI – Quality Management/Quality Improvement

RA – Remittance Advice

RAC – Recovery Audit Coordinator

RDBMS – Relational Database Management System

RFP – Request for Proposals

RHC – Rural Health Clinic

RN – Registered Nurse

ROW – Residential Options Waiver

RSDI – Retirement, Survivors, and Disability Insurance

SAM – System of Award Management

SBHC – School Based Health Center

SBHS – Specialized Behavioral Health Services

SDF – Software Development Firm

SDOH – Social Determinants of Health

SFTP – Secure File Transfer Protocol

SFY – State Fiscal Year

SHCN – Special Health Care Needs

SHP – STD /HIV Program

SIU – Special Investigation Unit

SLMB – Specified Low-Income Medicare Beneficiary

SMART-- Specific, Measurable, Action-Oriented, Realistic, and Time-Limited

SMI – Serious Mental Illness

SNAP – Supplemental Nutrition Assistance Program

SPA – State Plan Amendment

SSA – Social Security Act

SSI – Supplemental Security Income

SUD – Substance Use Disorder

SURS – Surveillance and Utilization Review Subsystems

TANF – Temporary Assistance for Needy Families

TCOC – Total Cost of Care

TDD – Telecommunications Device for the Deaf

TEDS – Treatment Episode Data Sets

TGH – Therapeutic Group Home

TJC – The Joint Commission

TPL – Third Party Liability

TTY/TDD – Telephone Typewrite and Telecommunications Device for the Deaf

UM – Utilization Management

UPS – Uninterruptible Power System

UR – Utilization Review

U.S.C. – United States Code

VAB – Value Added Benefit

VBP – Value-Based Payment

VPN – Virtual Private Network

WAA – Wraparound Agency

WIC – Women, Infants and Children Program

PART 2: CONTRACTOR RESPONSIBILITIES

2.1 Compliance

2.1.1 The Contractor shall comply, to the satisfaction of LDH, with: (1) all requirements set forth in this Contract; (2) all provisions of state and federal laws, regulations, rules, the State Plan, and waivers applicable to managed care; and (3) the **MCO Manual**.

2.1.2 The Contractor shall comply with federal statutes and regulations governing managed care, including, but not limited to, all applicable provisions of 42 U.S.C. § 1396u-2 and 42 C.F.R. Part 438 during the term of this Contract.

2.1.3 The Contractor shall cooperate with LDH, CMS, the External Quality Review Organization, the University of Louisiana at Monroe's Office of Outcomes Research and Evaluation, and any other LDH contractors related to the evaluation and monitoring of this Contract, the Contractor, or the Louisiana Medicaid managed care program.

2.1.4 Neither the Contractor nor any material subcontractor shall, for the duration of the Contract, have any interest that will conflict, as determined by LDH, with the performance of services under the Contract, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, LDH requires that neither the Contractor nor any material subcontractor have any financial, legal, contractual or other business interest in any entity performing MCO enrollment functions for LDH, the enrollment broker and subcontractor(s), if any.

2.1.5 The Contractor shall comply with all court-ordered requirements, including but not limited to, United States v. State of Louisiana (DOJ Agreement- Case-3:18-cv-00608) and Chisholm v. Gee (Case 2:97-cv-03274) in the manner determined by LDH.

2.1.6 The Contractor shall establish and maintain interdepartmental structures and processes to support the operation and management of this Contract in a manner that fosters integration of physical and behavioral health service provision. The provision of all services shall be based on prevailing clinical knowledge and the study of data on the efficacy of treatment, when such data is available.

2.1.7 The Contractor shall notify LDH in writing when there has been a significant change in its operations. The written notification shall include the details of the change and an assurance that it will not impact the ability of the Contractor to comply with the requirements of this Contract.

2.1.8 The Contractor shall comply with all of the reporting requirements established by this Contract and in accordance with the **MCO Manual**.

2.2 Contract Transition & Readiness

2.2.1 Transition Phase

The Contractor shall submit to LDH as part of readiness reviews, for its review and approval, a Transition Work Plan that demonstrates how it will accomplish required tasks before the operational start date, including:

2.2.1.1 Project management structure;

2.2.1.2 Communication protocols between LDH and the Contractor;

2.2.1.3 Interaction with LDH contractors;

2.2.1.4 Schedule for key activities and milestones; and

2.2.1.5 Evidence of completion of activities required for readiness review.

2.2.2 Readiness Review

2.2.2.1 LDH will complete readiness reviews of the Contractor prior to the operational start date in accordance with 42 CFR §438.66(c) - (d). LDH will provide the Contractor with the readiness review schedule. The Contractor 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 Contract. A portion of the readiness review will be performed onsite at the Contractor's administrative office. The Contractor 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).

2.2.2.2 The Contractor must disclose any changes to proposed key staff, subcontractors, or value added benefits identified in the proposal.

2.2.2.3 The Contractor must have successfully met all readiness review requirements established by LDH no later than sixty (60) calendar days prior to the contract start date.

2.2.2.4 If the Contractor 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 Contractor is not operational.

2.2.2.5 The Contractor 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 Contractor 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.

2.2.2.6 System Readiness

2.2.2.6.1 The Contractor will define and test modifications to the Contractor's system(s) required to support the business functions of the contract. The Contractor will produce data extracts and receive data transfers and

transmissions. The Contractor must be able to demonstrate the ability to produce encounter files.

2.2.2.6.2 If any errors or deficiencies are evident, the Contractor will develop resolution procedures to address the problem identified. The Contractor will provide LDH, or designated contractor, with test data files for systems and interface testing for all external interfaces.

2.3 Administration & Contract Management

2.3.1 General Staffing Requirements

2.3.1.1 The Contractor shall have in place organizational, operational, managerial, and administrative systems capable of fulfilling all Contract requirements. The Contractor shall recruit, develop and retain a diverse and qualified staff in numbers appropriate to the Contractor's enrollment, as described further below.

2.3.1.2 The Contractor shall not employ or subcontract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any federal healthcare program. The Contractor shall screen all potential employees and subcontractors to determine whether any of them have been excluded from participation in federal healthcare programs utilizing, at a minimum, the following websites:

- Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE);
- Louisiana Adverse Actions List Search;
- The System of Award Management (SAM); and
- Other applicable sites as may be determined by LDH.

2.3.1.3 The Contractor shall employ sufficient staffing and utilize appropriate resources to achieve contractual compliance. The Contractor's resource allocation shall be adequate to achieve positive outcomes in all functional areas within the organization. Adequacy shall be evaluated based on outcomes and compliance with the requirements of the Contract and the **MCO Manual**, including the requirement for providing culturally competent services. If the Contractor does not achieve the desired outcomes or maintain compliance with contractual obligations, non-compliance action may be employed by LDH, including but not limited to, requiring the Contractor to hire additional staff and the application of monetary penalties as specified in Attachment E, *Table of Monetary Penalties*.

2.3.1.4 The Contractor shall conduct an annual criminal background check on all current or potential employees or subcontractors who have access to enrollee protected health information. The Contractor 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 of its staff or subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this Contract.

2.3.1.5 On an ad hoc basis when changes occur or as directed by LDH, the Contractor shall submit to LDH an overall organizational chart that includes senior and mid-level managers for the organization. The organizational chart shall include the organizational staffing for behavioral health services and activities. If such behavioral health services and activities are provided by a material subcontractor, the Contractor shall submit the organizational chart of the behavioral health material subcontractor which clearly demonstrates the relationship with the material subcontractor and the Contractor's oversight of the material subcontractor to support the functional integration of physical and behavioral health. For all organizational charts, the Contractor shall indicate any staff vacancies and provide a timeline for when such vacancies will be filled.

2.3.1.6 The Contractor shall submit to LDH a listing of its Board of Directors as of the Contract execution date and an updated listing of its Board of Directors whenever any changes are made.

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

2.3.1.8 The Contractor shall identify the positions included in this section as key personnel. Unless specifically approved by LDH, all key personnel shall be full-time, based in Louisiana and only serve in one key personnel position.

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

2.3.1.10 The Contractor shall inform LDH in writing within five (5) business days when an employee in a key personnel position provides notice of resignation regardless of the reason for departure or when the Contractor has terminated an employee in a key personnel position. The Contractor shall inform LDH in writing as early as practicable when an employee in a key personnel position resigns without notice. The name of the individual serving in that role on an interim basis shall be provided prior to the departure date.

2.3.1.11 The Contractor shall seek written LDH pre-approval for all key personnel positions.

2.3.2 Exception to Staffing Requirements

2.3.2.1 Requests for exceptions to mandatory staffing requirements shall be submitted in writing to LDH for prior approval.

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

2.3.2.3 The Contractor shall provide and have an LDH approved staffing plan that describes how the Contractor shall maintain the staffing level to ensure the successful

accomplishment of all duties including specialized behavioral health related functions.

2.3.2.4 The Contractor may propose to LDH a staffing plan that combines positions and functions outlined in the Contract with other positions, provided the Contractor describes how the staffing roles delineated in the Contract will be addressed.

2.3.3 Key Personnel

The following positions are designated as key personnel and shall be located in Louisiana.

2.3.3.1 The **Chief Executive Officer (CEO)** shall provide overall direction for this Contract, develop strategies, formulate policies, and oversee operations to ensure goals are met. The CEO shall be a full-time position (minimum forty (40) hours weekly) based in Louisiana. The CEO shall serve exclusively in this position and may not function in an executive capacity for another insurance product. The CEO shall be the primary contact for LDH regarding all issues and shall coordinate with other key personnel to fulfill the requirements of the Contract. The CEO shall attend all CEO designated meetings in person.

2.3.3.2 The **Chief Operating Officer (COO)** shall manage day-to-day operations of multiple levels of staff and multiple functions/departments across the MCO to meet the performance requirements of the Contract. The COO shall be accountable to the CEO for operational results and may be designated to serve as the primary point-of-contact for all MCO operational issues. The COO shall be a full-time position (minimum forty (40) hours weekly) based in Louisiana. The COO may not function in an executive capacity for another insurance product. The COO shall attend meetings in person, when requested.

2.3.3.3 The **Medical Director/Chief Medical Officer (CMO)** shall be a physician with a current, unencumbered license through the Louisiana State Board of Medical Examiners. The Medical Director shall have at least three (3) years of training in a medical specialty and five (5) years of experience post-training providing clinical services. The physician shall have achieved board certification in his or her specialty. The Medical Director shall be located in Louisiana and shall be involved in all major clinical and quality management components of the MCO's activities. The Medical Director shall be devoted full-time (minimum forty (40) hours weekly) to the Contractor's operations and shall be responsible for ensuring timely medical decisions, including after-hours consultation, as needed. During periods when the Medical Director is not available, the Contractor shall have physician staff available to provide competent medical direction. The Medical Director shall serve exclusively in this position and may not function in an executive capacity for another insurance product. The Medical Director shall be responsible for:

2.3.3.3.1 Development, implementation and medical interpretation of clinical policies and procedures, including, but not limited to, service authorization, claims review, discharge planning, credentialing and referral management,

utilization management and medical review included in the MCO Grievance System;

2.3.3.3.2 Administration of all medical management activities of the MCO;

2.3.3.3.3 Coordinating with the Behavioral Health Medical Director to integrate the administration and management of behavioral and physical health services;

2.3.3.3.4 Serving as member of and participating in every meeting of the Medicaid Quality Committee in person. The Medical Director may designate a representative with a working understanding of the clinical and quality issues impacting Medicaid; and

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

2.3.3.4 The **Behavioral Health Medical Director** shall be a physician with a current, unencumbered Louisiana-license as a physician, board-certified in psychiatry with at least three (3) years of training in a medical specialty. The Behavioral Health Medical Director shall be devoted full-time (minimum forty (40) hours weekly) to the Contractor's operations to ensure timely medical decisions, including after-hours consultation, as needed. During periods when the Behavioral Health Medical Director is not available, the Contractor shall have physician staff available to provide competent medical direction. The Behavioral Health Medical Director shall serve exclusively in this position and may not also function in an executive capacity for another insurance product.

The Behavioral Health Medical Director shall share responsibility for the management of the behavioral health services delivery system with the Behavioral Health Coordinator, and shall be actively involved in all major clinical and quality management components of the behavioral health services of the MCO. The Behavioral Health Medical Director shall meet regularly with the Medical Director. The Behavioral Health Medical Director's responsibilities shall include, but not be limited to, the following:

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

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

2.3.3.4.3 Develop comprehensive care programs for the management of youth and adult behavioral health concerns typically treated by PCPs, such as ADHD and depression;

2.3.3.4.4 Develop targeted education and training for MCO PCPs to screen for mental health and substance use disorders using evidence-based tools (e.g., AUDIT-C, PHQ-9 and GAD-7), perform diagnostic assessments, provide counseling and prescribe pharmacotherapy when indicated, and build collaborative care models in their practices;

2.3.3.4.5 Coordinate with the Medical Director to integrate the administration and management of behavioral and physical health services;

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

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

2.3.3.5 The **Chief Financial Officer (CFO)** shall oversee the budget, accounting systems, financial reporting, and all audit activities implemented by the Contractor. The CFO shall be a full-time position (minimum forty (40) hours weekly) based in Louisiana and may not function in an executive capacity for another insurance product. He or she shall attend meetings in person, when requested.

2.3.3.6 The **Pharmacy Director** shall be located and licensed in Louisiana, with at least five (5) years' experience as a pharmacist practicing in a retail setting with managerial experience. The Pharmacy Director shall serve full-time (minimum forty (40) hours weekly) and may not function in this capacity for another insurance product. He or she shall attend meetings in person, when requested.

2.3.3.7 The **Contract Compliance Officer** shall serve as the primary point of contact for all communications and requests related to this Contract, including but not limited to, all compliance issues. The incumbent shall manage the connection of MCO personnel to LDH business owners, and shall develop and implement written policies, procedures, and standards to ensure compliance with the requirements of this Contract. These primary functions may include, but are not limited to, coordinating the tracking and submission of all Contract deliverables, fielding and coordinating responses to LDH inquiries, coordinating the preparation and execution of Contract documents, audits and ad hoc visits. This position shall report directly to the CEO and board of directors in accordance with 42 C.F.R. §438.608(a)(1)(ii).

2.3.4 Additional Required Staff

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

2.3.4.2 The Contractor shall comply with additional staffing requirements included in the **MCO Manual**.

2.3.5 Written Policies, Procedures, and Job Descriptions

2.3.5.1 The Contractor shall develop and maintain written policies, procedures and job descriptions for each functional area that are consistent in format and style. The Contractor shall maintain written guidelines for developing, reviewing and approving all policies, procedures and job descriptions.

2.3.5.2 All policies and procedures shall be reviewed at least annually to ensure that the Contractor's written policies reflect current practices. Reviewed policies shall be dated and signed by the Contractor's appropriate manager, coordinator, director or CEO. Minutes reflecting the review and approval of the policies by an appropriate committee are also acceptable documentation. All medical and quality management policies shall be approved and signed by the Contractor's Medical Director. All behavioral health policies shall be approved and signed by the Contractor's Behavioral Health Medical Director. Job descriptions shall be reviewed at least annually to ensure that current duties performed by the employee reflect written requirements.

2.3.5.3 If LDH deems a Contractor policy or process to be insufficient and/or places an unnecessary burden on the enrollees or providers, the Contractor shall be required to work with LDH to change the policy or procedure within a time period specified by LDH.

2.3.6 Staff Training, Licensure, and Meeting Attendance

2.3.6.1 The Contractor shall ensure that all staff members, including subcontractors, have met any applicable state or federal licensure requirements and have received appropriate training, education, experience and orientation to fulfill their requirements of the position. LDH may require additional staffing for a Contractor that has substantially failed to maintain compliance with any provision of the Contract.

2.3.6.2 The Contractor shall provide initial and ongoing staff training that includes an overview of contractual, state and federal requirements specific to individual job functions. The Contractor shall ensure that all staff members having contact with enrollees or providers receive initial and ongoing training on health equity and social determinants of health and with regard to the appropriate identification and handling of quality of care concerns.

2.3.6.3 The Contractor shall educate all staff members about its policies and procedures on advance directives.

2.3.6.4 New and existing transportation, prior authorization, provider services and enrollee service representatives shall be trained in the geography of Louisiana, as well as its culture and the correct pronunciation of cities, towns, and surnames. They shall have access to GPS or mapping search engines for the purposes of authorizing services in, and recommending providers and transporting enrollees to, the most geographically appropriate location.

2.3.6.5 The Contractor shall provide subject appropriate staff to attend and participate in meetings or events, which may be on-site, scheduled by LDH. All meetings shall be considered mandatory unless otherwise indicated.

2.3.6.6 LDH reserves the right to attend all training programs and seminars conducted by the Contractor. The Contractor shall provide LDH a list of any marketing training dates (See *Enrollee Services* section), time and location, at least fourteen (14) calendar days prior to the actual date of training. The Contractor shall provide documentation of meetings and trainings (including staff and provider trainings) upon request. Meeting minutes, agendas, invited attendee lists and sign-in sheets along with action items shall be provided upon request.

2.3.6.7 LDH reserves the right to assign mandatory training for key staff, other staff, and subcontractors. The Contractor may be required to submit documentation that all staff have completed LDH assigned mandatory training, education, professional experience, orientation, and credentialing, as applicable, to perform assigned job duties.

2.3.6.8 Additional staff training requirements shall include but not be limited to:

2.3.6.8.1 For case managers and case management supervisors:

2.3.6.8.1.1 Specialized behavioral health policy contained in the **MCO Manual**;

2.3.6.8.1.2 Coordinated System of Care (CSoC) system of care values, the wraparound process, and processes and protocols for screening and referral;

2.3.6.8.1.3 OJJ system, population, and processes;

2.3.6.8.1.4 DCFS system, population, and processes;

2.3.6.8.1.5 Contract requirements;

2.3.6.8.1.6 Approved waivers and State Plan amendments for specialized behavioral health;

2.3.6.8.1.7 Specialized behavioral health services for enrollees residing in a nursing facility and/or included in the DOJ Agreement Target Population;

2.3.6.8.1.8 Pre-admission screening and resident review (PASRR);

2.3.6.8.1.9 Services provided by the Office for Citizens with Development Disabilities;

2.3.6.8.1.10 Current and applicable evidence-based practices;

2.3.6.8.1.11 Behavioral health services available through other funding sources, including Medicare; and

2.3.6.8.1.12 Permanent Supportive Housing provided by the Office of Aging and Adult Services.

2.3.6.8.2 For staff members having contact with enrollees or providers – initial and ongoing training with regard to the appropriate identification and handling of quality of care concerns.

2.3.6.8.3 For staff members working directly with enrollees – Crisis intervention training.

2.3.7 Material Subcontracts/Subcontractors

2.3.7.1 Prior to contracting with a material subcontractor, the Contractor shall evaluate the prospective material subcontractor's ability to perform the activities to be subcontracted.

2.3.7.2 The Contractor shall request prior approval of all material subcontracts, amendments, and substitutions from LDH. To obtain such approval, the Contractor shall submit a written request and a completed material subcontractor checklist using the template provided by LDH included in the **MCO Manual**. The request shall also describe how the Contractor will oversee the material subcontractor.

2.3.7.3 The Contractor shall provide LDH with any additional information requested by LDH in addition to the information required in the checklist, including identifying whether the proposed material subcontractor is part of an organization related to the Contractor.

2.3.7.4 The material subcontract shall:

2.3.7.4.1 Be written;

2.3.7.4.2 Specify, and require compliance with, all applicable requirements of this Contract and the activities and reporting responsibilities the material subcontractor is obligated to provide;

2.3.7.4.3 Provide for imposing penalties, including Contract termination, if the State or the Contractor determines that the material subcontractor's performance is inadequate or non-compliant;

2.3.7.4.4 Require the material subcontractor to comply with all applicable Medicaid laws, regulations, and applicable subregulatory guidance; and

2.3.7.4.5 Comply with the audit and inspection requirements set forth in 42 C.F.R. §438.230(c)(3) and 42 C.F.R. §438.3(k).

2.3.7.5 The State, including LDH, Louisiana Office of the Attorney General Medicaid Fraud Control Unit (MFCU), and the Louisiana Legislative Auditor (LLA), and the federal government, including, CMS, HHS Inspector General, and the General Accounting Office, or their designees, have the right to audit, evaluate, and inspect any records or systems that pertain to any activities performed or amounts payable under this Contract at any time.

2.3.7.5.1 This right exists for ten (10) years from the termination of this Contract for the Contractor and any material subcontractors or from the date of completion of any audit, whichever is later; provided, however that if any of the entities above determine that there is a reasonable possibility of fraud or similar risk, they may audit, evaluate, and inspect at any time;

2.3.7.5.2 The Contractor and any material subcontractors shall make their premises, facilities, equipment, records, and systems available for the purposes of any audit, evaluation, or inspection described immediately above;

2.3.7.5.3 The Contractor and any material subcontractors shall retain, as applicable, enrollee grievance and appeal records in 42 C.F.R. §438.416, base data in 42 C.F.R. §438.5(c), MLR reports in 42 C.F.R. §438.8(k), and the data, information, and documentation specified in 42 C.F.R. §438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years; and

2.3.7.5.4 The Contractor shall monitor any material subcontractor's performance on an ongoing basis and perform a formal review annually. At a minimum, the annual review shall include any performance concerns identified by LDH. If any deficiencies or areas for improvement are identified, the Contractor shall require the material subcontractor to take corrective action. The Contractor shall provide LDH with a copy of the annual review and any corrective action plans developed as a result. If there are corrective active plans put in place, the Contractor shall provide ongoing updates to LDH on the material subcontractor's activities to improve the performance pursuant to the corrective action plan.

2.3.7.6 Upon notifying any material subcontractor, or upon being notified by such material subcontractor, of the intention to terminate such subcontract, the Contractor shall notify LDH in writing no later than the same day as such notification, and shall otherwise support any necessary enrollee transition or related activities as described in the *Continuity of Care* section and elsewhere in this Contract.

2.3.7.7 The Contractor shall require that all Material Subcontracts stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law.

2.3.7.8 Notwithstanding any relationship the Contractor may have with a subcontractor, including material subcontractors, the Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract. No subcontractor will operate to relieve the Contractor of its legal responsibilities under the Contract.

2.3.8 Contract Management and Responsiveness to LDH

In addition to the other requirements of this Contract, Contractor shall ensure and demonstrate appropriate responsiveness to LDH requests related to this Contract, as follows:

2.3.8.1 Performance Reviews

2.3.8.1.1 The Contractor shall attend regular performance review meetings held by LDH at LDH's offices, or at another location determined by LDH, each quarter or more frequently at LDH's discretion;

2.3.8.1.2 The Contractor shall ensure that key personnel and other staff with appropriate expertise are present in person at such meetings, as requested by LDH, including but not limited to, the Contractor's CEO;

2.3.8.1.3 The Contractor shall prepare materials and information for such meetings as further directed by LDH, including but not limited to, materials and information such as:

2.3.8.1.3.1 Reports, in a form and format approved by LDH, on Contractor's performance under this Contract, including but not limited to, measures such as:

- Costs of care for enrollees by program and category of service;
- Performance reporting information;
- Quality measure performance;
- Measures of enrollee utilization across categories of service and other indicators of changes in patterns of care;
- Variation and trends in any such performance measures at the level of individual PCPs;
- Completeness and validity of any data submissions made to LDH;
- Opportunities the Contractor identifies to improve performance and plans to improve such performance, including plans proposed to be implemented by the Contractor for PCPs or other network providers;
- Changes in Contractor's staffing and organizational development;
- Performance of material subcontractors, including but not limited to, any changes in or additions to material subcontractor relationships; and

- Any other measures deemed relevant by Contractor or requested by LDH.

2.3.8.1.3.2 Updates and analytic findings from any reviews requested by LDH, such as reviews of data irregularities; and

2.3.8.1.3.3 Updates on any action items and requested follow-ups from prior meetings or communications with LDH.

2.3.8.1.4 The Contractor shall, within two (2) business days following each performance review meeting, prepare and submit to LDH for review and approval a list of any action items, requested follow-ups for the next meeting, and estimated timelines for delivery, in a form and format specified by LDH.

2.3.8.2 Program Integrity Requirements

The Contractor shall meet following requirements:

2.3.8.2.1 Notify LDH upon contact by any investigative authorities conducting fraud and abuse investigations, except in situations where investigative authorities make it illegal to provide such notice. The Contractor, and where applicable any subcontractors or material subcontractors, shall cooperate fully with the agencies that conduct investigations; full cooperation includes, but is not limited to, timely exchange of information and strategies for addressing fraud and abuse, as well as allowing prompt direct access to information, free copies of documents, and other available information related to program violations, while maintaining the confidentiality of any investigation. The Contractor shall make knowledgeable employees available at no charge to support any investigation, court, or administrative proceeding;

2.3.8.2.2 Notify LDH in writing upon receipt of any voluntary provider disclosures resulting in receipt of overpayments in excess of $25,000, even if there is no suspicion of fraudulent activity; and

2.3.8.2.3 Report annually to LDH, in a form and format specified by LDH, on the Contractor's recoveries of overpayments in accordance with 42 C.F.R. §438.608.

2.3.9 Continuity of Operations Plan

The Contractor shall maintain a continuity of operations plan that addresses how the Contractor's, material subcontractors', and other subcontractors' operations shall be maintained in the event of a natural disaster, terrorist attack, pandemic or other event which leads to a significant disruption in operations due to staff absence and/or loss of utilities. The Contractor shall provide copies of such plan to LDH upon request and shall inform LDH whenever such plan must be implemented.

2.3.10 Reports and Requests for Information

2.3.10.1 The Contractor shall provide and require its subcontractors to provide, as applicable, in accordance with the timelines, definitions, formats and instructions contained herein or as further specified by LDH in the **MCO Manual**:

2.3.10.1.1 All information required under this Contract, or other information related to the performance of contract responsibilities as reasonably requested by LDH;

2.3.10.1.2 All reports and associated requirements as specified in the **MCO Manual**;

2.3.10.1.3 Any data from their clinical systems, authorization systems, claims systems, medical record reviews, network management visits, and enrollee and family input;

2.3.10.1.4 Delivery of time sensitive data to LDH in accordance with LDH timelines; and

2.3.10.1.5 High quality, accurate data in the format and in the manner of delivery specified by LDH.

2.3.10.2 The following timelines shall apply to requests for information from LDH:

2.3.10.2.1 Requests that originate with the Louisiana governor's office, the office of the LDH secretary, or a Louisiana legislator – seventy-two (72) hours;

2.3.10.2.2 Requests from the LDH Provider Relations Unit – five (5) business days;

2.3.10.2.3 Requests from the LDH Member Complaints Unit and requests for assistance with locating specialists – seventy-two (72) hours unless there is a clinical indication that it is needed sooner.

2.3.10.3 The Contractor shall comply with the following requirements specific to public records' requests:

2.3.10.3.1 Prior to the operational start date, 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 immediately.

2.3.10.3.2 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, deems to be responsive to the request, pursuant to the timeline and in the requested format established by LDH.

2.3.10.3.3 If the Contractor receives the public records' request directly, the Contractor shall forward the request via email to the LDH 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, in its sole discretion, deems to be responsive to the request, pursuant to the timeline and in the requested format established by LDH.

2.3.10.4 A pattern of inadequate or untimely responses to requests for information shall be subject to monetary penalties in accordance with Attachment E, *Table of Monetary Penalties*.

2.3.11 Mental Health Parity

2.3.11.1 The Contractor shall comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations. The Contractor shall comply with all requirements set forth in 42 C.F.R. Part 438 Subpart K, for all Medicaid managed care enrollees.

2.3.11.1.1 The Contractor must comply with parity requirements for aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits, including prescription drugs as specified in 42 C.F.R. §438.905.

2.3.11.1.2 All financial requirements or treatment limitations, including nonquantitative treatment limitations (NQTL), to mental health or substance use disorder benefits shall not be more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits, in accordance with 42 C.F.R. §438.910. Financial requirements cannot accumulate separately for medical/surgical benefits and mental health/SUD benefits.

2.3.11.2 The Contractor shall develop and maintain internal controls to ensure mental health parity. The Contractor's utilization practices such as prior authorization, standards for medical necessity determination, and network policy, procedures, and practices shall comply with the federal regulations referenced above.

2.3.11.2.1 The Contractor shall conduct an initial parity analysis as part of its readiness review process and at other times as directed by LDH, based on benefit classifications for parity as defined by LDH. If an enrollee is provided mental health or substance use disorder benefits in any classification of benefits, mental health and substance use disorder benefits must be provided to the enrollee in every classification in which medical/surgical benefits are provided.

2.3.11.2.2 The Contractor shall cover, in addition to State Plan required services, any service necessary for compliance with the requirements for parity in mental health and substance use disorder benefits based on parity analysis. As directed by LDH as part of ongoing parity review, the Contractor may be required to cover or change services necessary for compliance including type and amount, duration and scope of services and change policy or operational procedures in order to achieve and maintain compliance with parity requirements.

2.3.11.2.3 The Contractor shall ensure enrollees receive a notice of adverse benefit determination per 42 C.F.R. §438.915(b) and other sections of this Contract which extend notice requirements beyond denials. The Contractor shall make available in hard copy upon request at no cost to the requestor and available on the Contractor's website, the criteria for medical necessity determinations for mental health and substance use disorder benefits to any enrollee, potential enrollee or provider per 42 C.F.R. §438.236(c) and 438.915(a).

2.3.11.3 The Contractor shall require that all providers and all subcontractors take such actions as are necessary to ensure compliance with mental health parity requirements. To the extent that the Contractor delegates oversight responsibilities for behavioral health services to a material subcontractor, the Contractor shall require that the material subcontractor complies with provisions of this Contract relating to mental health parity. The compliance and review shall be in conjunction with parity analysis on the medical/surgical benefit administration. The Contractor shall require mental health parity disclosure on provider enrollment forms as mandated by LDH.

2.3.11.3.1 If at any time the State moves to a single delivery system and any remaining benefits from FFS are completely provided through managed care, it shall be the responsibility of the Contractor to review mental health and substance user disorder and medical/surgical benefits and conduct the complete parity analysis to ensure the full scope of services available to all enrollees of the Contractor complies with the requirements set forth in 42 C.F.R. Part 438, Subpart K. The Contractor shall be required to provide documentation to the State and public.

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

2.3.11.5 The Contractor shall comply with all other applicable state and federal laws and regulations relating to mental health parity.

2.4 Eligibility and Enrollment

2.4.1 Mandatory MCO Populations for All MCO Covered Services

Unless otherwise excluded in this section, the following Medicaid populations are automatically enrolled into Medicaid managed care and are mandated to receive all MCO covered services:

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

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

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

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

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

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

2.4.1.1.6 LaCHIP Program – Children enrolled in the Title XIX Medicaid expansion and separate CHIP programs for uninsured low-income children under age nineteen (19) who do not otherwise qualify for Medicaid;

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

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

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

2.4.1.2.1 Parents and Caretaker Relatives Program

2.4.1.2.2 Regular Medically Needy Program

2.4.1.3 Pregnant Women – Individuals whose basis of eligibility is pregnancy, who are eligible only for pregnancy related services [42 C.F.R. §440.210(a)(2)] including:

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

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

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

2.4.1.5 Aged, Blind, and Disabled Adults – Individuals who (1) are age 65 or older, blind, or have a disability, (2) meet financial eligibility criteria, and (3) do not meet the conditions for inclusion in the voluntary opt-in populations, mandatory specialized behavioral health and non-emergency ambulance transportation populations, and mandatory specialized behavioral health and non-emergency medical transportation populations. These include:

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

2.4.1.5.2 Extended Medicaid Programs – Certain individuals who lose SSI eligibility because of a Social Security cost of living adjustment (COLA) or in some cases entitlement to or an increase in Retirement, Survivors, Disability Insurance (RSDI) benefits, i.e., Social Security benefits. SSI income standards are used in combination with budgeting rules which allow the exclusion of cost of living adjustments and/or certain benefits. Extended Medicaid consists of the following programs:

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

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

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

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

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

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

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

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

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

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

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

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

2.4.1.8 Adult Expansion – Individuals age 19 through 64, not otherwise categorically eligible, with incomes at or below 133% FPL.

2.4.2 Voluntary Opt-In Populations

The Contractor shall accept enrollment of the following Medicaid populations and provide for all Specialized Behavioral Health, Non-Emergency Medical Transportation (NEMT) services and Non-Emergency Ambulance Transportation (NEAT) Services.

2.4.2.1 If any such beneficiary voluntarily enrolls into Medicaid Managed Care for all other State Plan covered services, the Contractor shall provide for all services specified in the *Services* section. These populations include:

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

2.4.2.1.1.1 Adult Day Health Care Waiver (ADHC) – Direct care in a licensed adult day health care facility for those individuals who would otherwise require nursing facility services;

2.4.2.1.1.2 New Opportunities Waiver (NOW) – Services to individuals who would otherwise require ICF/DD services;

2.4.2.1.1.3 Children's Choice Waiver (CC) – Supplemental support services to disabled children on the NOW waiver registry;

2.4.2.1.1.4 Residential Options Waiver (ROW) – Services to individuals living in the community who would otherwise require ICF/DD services;

2.4.2.1.1.5 Supports Waiver – Services to individuals 18 years and older with a developmental disability which manifested prior to age 22; and

2.4.2.1.1.6 Community Choices Waiver (CCW) – Services to persons aged 65 and older or, persons with adult-onset disabilities age 22 or older, who would otherwise require nursing facility services.

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

2.4.2.2 Voluntary opt-in populations may elect to receive all other State Plan services through Medicaid Managed Care at any time.

2.4.2.3 Voluntary opt-in populations may return to FFS Medicaid for all State Plan services other than Specialized Behavioral Health and NEMT effective the earliest possible month that the administrative action can be taken.

2.4.2.4 Voluntary opt-in populations who have previously returned to FFS Medicaid for all State Plan services other than Specialized Behavioral Health and NEMT may exercise this option to return to Medicaid Managed Care for other State Plan services only during the annual open enrollment period**.**

2.4.3 Mandatory MCO Populations for Specialized Behavioral Health Services and Non-Emergency Transportation only. These populations include:

2.4.3.1 Individuals residing in Nursing Facilities (NF); and

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

2.4.4 Mandatory MCO Populations – Specialized Behavioral Health and Non-Emergency Medical Transportation (NEMT) Services

2.4.4.1 Individuals who receive both Medicaid and Medicare (Medicaid dual eligible) are mandatorily enrolled in Medicaid Managed Care for Specialized Behavioral Health

Services and non-emergency medical transportation, including non-emergency ambulance transportation, unless residing in an institution as specified in this section.

2.4.4.2 LaHIPP enrollees are mandatorily enrolled in Medicaid Managed Care for Specialized Behavioral Health Services, and non-emergency medical transportation, including non-emergency ambulance transportation, unless residing in an institution as specified in this section.

2.4.5 Mandatory MCO Populations – All MCO Covered Services except Specialized Behavioral Health and CSoC services

The Contractor shall accept enrollment of children who are functionally eligible and participate in the CSoC program for all services specified in the *Services* section, except Specialized Behavioral Health Services and Coordinated System of Care (CSoC) services. For this population, Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (TGH), and Substance Use Disorder (SUD) Residential services (ASAM Levels 3.1, 3.2-wm, 3.5 and 3.7) remain the responsibility of the MCO. The Contractor shall implement procedures to coordinate services it provides to the enrollee with the services the enrollee receives from the CSoC contractor, including sharing the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities as required by 42 C.F.R. §438.208(b)(4).

2.4.6 Excluded Populations

Medicaid populations that cannot participate in Medicaid managed care include:

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

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

2.4.6.3 Refugee Cash Assistance;

2.4.6.4 Refugee Medical Assistance;

2.4.6.5 Take Charge Plus;

2.4.6.6 SLMB only;

2.4.6.7 QI-1;

2.4.6.8 LTC Co-Insurance;

2.4.6.9 QDWI;

2.4.6.10 QMB only; and

2.4.6.11 Individuals with a limited eligibility period including:

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

2.4.6.11.2 Emergency Services Only – Emergency services for aliens who do not meet Medicaid citizenship/ 5-year residency requirements.

2.4.7 Changes to Population Groups

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

2.4.8 Eligibility, Enrollment and Disenrollment

The Contractor shall abide by all Medicaid managed care enrollment and disenrollment procedures. Auto assignment algorithms and decisions regarding MCO enrollment are at the sole discretion of LDH and the Contractor must abide by those decisions.

2.4.9 Voluntary Selection of MCO for New Enrollees

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

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

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

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

2.4.10 Assistance with Medicaid Eligibility Renewal

Renewals of Medicaid and CHIP eligibility are conducted annually. At least thirty (30) calendar days prior to the renewal date as indicated on the 834 file, the Contractor shall provide assistance to enrollees with eligibility renewals. The Contractor shall attempt to contact the enrollee by mail and/or phone three (3) times to encourage their timely response to the renewal.

2.4.11 Suspension of and/or Limits on Enrollments

2.4.11.1 The Contractor shall identify the maximum number of enrollees it is able to enroll and maintain under the Contract prior to initial enrollment. LDH reserves the right to approve or deny the maximum number of enrollees to be enrolled in the MCO based on LDH's determination of the adequacy of MCO capacity.

2.4.11.2 In the event the Contractor's enrollment reaches thirty-five percent (35%) of the total enrollment in the state, or 95 percent (95%) of its capacity, at LDH's sole discretion, the Contractor shall not receive additional enrollees through the automatic assignment algorithm.

2.4.11.3 The Contractor may continue to receive new enrollees as a result of: enrollee choice and newborn enrollments; automatic reenrollments when an enrollee loses and regains eligibility within ninety (90) days; the need to ensure continuity of care for the enrollee; or determination of just cause by LDH. LDH's evaluation of an MCO's enrollment market share will take place on a calendar quarter basis.

2.4.12 MCO Enrollment Procedures

2.4.12.1 Acceptance of All Enrollees

2.4.12.1.1 The Contractor shall enroll any mandatory or voluntary Medicaid beneficiary who selects it or is assigned to it.

2.4.12.1.2 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 the Contract with LDH [42 C.F.R. §438.3(d)(1)].

2.4.12.1.3 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 MCO. The Contractor shall be subject to monetary penalties and other sanctions if it is determined by LDH that the MCO has requested disenrollment for any of these prohibited reasons.

2.4.12.1.4 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.

2.4.12.2 Effective Date of Enrollment

2.4.12.2.1 The effective date of initial enrollment in an MCO shall be the date provided on the outbound ANSI ASC X12N 834 Benefit Enrollment & Maintenance electronic transaction file initiated by the enrollment broker.

2.4.12.2.2 An enrollee's effective date of enrollment in an MCO shall be the same as the enrollee's effective date of eligibility for Medicaid, subject to the following limitations:

2.4.12.2.2.1 Individuals may be retroactively eligible for Medicaid. Individuals retroactively eligible for Medicaid may be retroactively enrolled in an MCO for a period limited to twelve (12) months.

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

2.4.12.2.3 The Contractor shall not be liable for the cost of any MCO covered services prior to the effective date of MCO enrollment but shall be responsible for the costs of MCO covered services obtained on or after 12:01 a.m. on the effective date of MCO enrollment.

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

2.4.12.2.5 Except for cost sharing that does not exceed the cost sharing amounts in the Medicaid State Plan, the Contractor shall ensure that enrollees are held harmless for the cost of MCO covered services provided as of the effective date of enrollment with the MCO.

2.4.12.3 Changes in Demographic Information or Status

2.4.12.3.1 The Contractor shall report to LDH in the manner and format determined by LDH 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 telephone number.

2.4.12.3.2 The Contractor shall submit notifications to LDH for other known changes in status which may affect eligibility for participation in Medicaid managed care, including, but not limited to, death, admission to an 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.

2.4.12.4 Newborn Enrollment

2.4.12.4.1 The Contractor shall contact enrollees who are expectant mothers at least sixty (60) calendar days prior to the expected date of delivery to encourage the mothers to choose a PCP for their newborns. In the event that the

pregnant enrollee does not select a PCP, the Contractor shall provide the enrollee with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one.

2.4.12.4.2 Medicaid deemed eligible newborns and their mothers, to the extent that the mother is eligible for Medicaid, shall be enrolled in the same MCO with the exception of newborns placed for adoption, newborns who are born out of state and are not Louisiana residents at the time of birth, and newborns and mothers eligible for Medicaid after the month of birth.

2.4.12.4.3 If LDH discovers that a newborn was incorrectly enrolled in an MCO different than its mother for the month of birth, LDH shall immediately:

2.4.12.4.3.1 Disenroll the newborn from the incorrect MCO;

2.4.12.4.3.2 Enroll the newborn in the correct MCO with the same effective date as when the newborn was enrolled in the incorrect MCO;

2.4.12.4.3.3 Recoup any payments made to the incorrect MCO for the newborn; and

2.4.12.4.3.4 Make payments only to the correct MCO for the period of coverage.

2.4.12.4.4 If the Contractor discovers that a newborn was incorrectly enrolled in an MCO different than its mother for the month of birth, the Contractor shall notify LDH immediately.

2.4.12.4.5 The MCO in which the newborn is correctly enrolled shall be responsible for the coverage and payment of MCO covered services provided to the newborn for the full period of eligibility. The MCO in which the newborn was incorrectly enrolled shall have no liability for the coverage or payment of any services during the period of incorrect MCO enrollment. LDH shall only be liable for the capitation payment to the correct MCO and may recoup the capitation payment from the MCO in which the newborn was incorrectly enrolled.

2.4.12.4.6 For newborns dis-enrolled, the MCO in which the newborn was incorrectly enrolled shall not recover claim payments from the provider. The MCO in which the newborn is incorrectly enrolled shall seek such claim payments from the MCO in which the newborn should have been enrolled on the dates of service.

2.4.12.4.7 The Contractor shall be responsible for ensuring that hospitals report the births of newborns within twenty-four (24) hours of birth for enrollees in accordance with the process outlined in the **MCO Manual**. Enrollment of deemed eligible newborns who are Louisiana residents at the time of birth and who are not surrendered prior to hospital discharge shall be retroactive to the date of the birth.

2.4.12.4.8 The Contractor shall require its hospital providers to register all births within fifteen (15) days through LEERS (Louisiana Electronic Event Registration System) administered by LDH/Vital Records Registry.

2.4.12.5 Justice-Involved Enrollees

All justice-involved enrollees releasing from incarceration shall be enrolled in accordance with the process outlined in the **MCO Manual**.

2.4.13 Disenrollment

2.4.13.1 General Requirements

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

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

2.4.13.2 Voluntary Disenrollment Requested by the Enrollee

An enrollee may request disenrollment from the MCO as follows:

2.4.13.2.1 **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 MCO and the enrollee's PCP 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 by the Contractor as determined by LDH;
- Lack of access to MCO covered services as determined by LDH;
- The enrollee's active specialized behavioral health provider ceases to contract with the Contractor for reasons other than non-compliance with the provider agreement or this Contract; or
- Any other reason deemed to be valid by LDH and/or its agent.

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

- During the ninety (90) calendar days following the date of the beneficiary's initial enrollment into the MCO 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 C.F.R. §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 C.F.R §438.702(a)(3); or
- After LDH notifies the Contractor that it intends to terminate the Contract as provided by 42 C.F.R. §438.722.

2.4.13.3 Involuntary Disenrollment Requested by the MCO

2.4.13.3.1 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 MCO-issued ID card to another person to obtain services. In such case the Contractor shall report the event to LDH and MFCU.

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

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

2.4.13.3.4 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, pre-existing 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 her/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 C.F.R. §438.56(b)(2)]

2.4.13.3.5 The Contractor shall not request disenrollment for reasons other than those stated in this Contract. In accordance with 42 C.F.R. §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.

2.4.13.3.6 All disenrollment requests shall be reviewed on a case-by-case basis and are subject to 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.

2.4.13.3.7 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:

2.4.13.3.7.1 The reason for the disenrollment;

2.4.13.3.7.2 The effective date;

2.4.13.3.7.3 An instruction that the enrollee choose a new MCO; and

2.4.13.3.7.4 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.

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

2.4.13.4 Disenrollment Effective Date

2.4.13.4.1 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.

2.4.13.4.2 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.

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

2.4.14 Enrollment and Disenrollment Updates

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

2.4.14.2 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.

2.4.15 Updates

The enrollment broker shall make available to the Contractor daily via electronic media (ASC X12N 834 Benefit Enrollment and Maintenance transaction) updates on beneficiaries newly enrolled into the MCO in the format specified in the **MCO Manual**. 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.

2.4.16 Reconciliation

2.4.16.1 Enrollment

The Contractor is responsible for monthly and quarterly reconciliation of the membership list of enrollments and disenrollments received from the enrollment broker against its 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.

2.4.16.2 Payment

The Contractor shall receive a monthly electronic file (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. Lack of compliance with reconciliation requirements shall result in the deduction of a portion of future monthly payments and/or monetary penalties as defined in Attachment E, *Table of Monetary Penalties* until requirements are met.

2.5 Services

2.5.1 MCO Covered Services

2.5.1.1 The Contractor shall provide enrollees all medically necessary MCO covered services specified in Attachment A, *MCO Covered Services,* as those services are defined in the Louisiana Medicaid State Plan and the **MCO Manual**. The Contractor shall possess the expertise and resources to ensure the delivery of quality healthcare services to its enrollees in accordance with this Contract and prevailing medical community and national standards.

2.5.1.2 MCO covered services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service (FFS) Medicaid, as set forth in 42 C.F.R. §440.230, and for enrollees under the age of 21, as set forth in 42 C.F.R. Part 441, Subpart B. [42 C.F.R. §438.210(a)(2)]

2.5.1.3 The Contractor shall ensure that MCO covered services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the enrollee. [42 C.F.R. §438.210(a)(3)]

2.5.1.4 In accordance with 42 C.F.R. §438.210(a)(4), the Contractor may place appropriate limits on a service that are:

2.5.1.4.1 On the basis of criteria applied under the State Plan, such as medical necessity; or

2.5.1.4.2 For the purpose of utilization control, provided that:

2.5.1.4.2.1 The services furnished can reasonably be expected to achieve their purpose;

2.5.1.4.2.2 The services support enrollees with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and

2.5.1.4.2.3 Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 C.F.R. §441.20.

2.5.1.5 The Contractor shall provide MCO covered services in accordance with LDH's definition of medically necessary services (see *Glossary*), including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and the **MCO Manual**. [42 C.F.R. §438.210(a)(5)(i)]

2.5.1.6 The Contractor shall cover medically necessary services that address:

2.5.1.6.1 The prevention, diagnosis and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability;

2.5.1.6.2 The ability for an enrollee to achieve age-appropriate growth and development; and

2.5.1.6.3 The ability for an enrollee to attain, maintain, or regain functional capacity.

2.5.1.7 The Contractor shall ensure that each enrollee has an ongoing source of care appropriate to their needs as required under 42 C.F.R. §438.208(b)(1) and shall formally designate a primary care provider as primarily responsible for coordinating services accessed by the enrollee, as further described in the *Provider Network, Contracts, and Related Responsibilities* section.

2.5.1.8 The Contractor shall not avoid costs for services covered in its Contract by referring enrollees to publicly supported health care resources. [42 C.F.R. §457.1201(p)]

2.5.1.9 The Contractor shall provide a mechanism to reduce inappropriate and duplicative use of healthcare services, including but not limited to potentially preventable hospital emergency departments visits and inpatient readmissions.

2.5.1.10 The Contractor shall not condition the provision of care or otherwise discriminate against an enrollee based on whether or not the enrollee has executed an advance directive. [42 C.F.R. §438.3(j)(1) and (2); 42 C.F.R. §489.102(a)(3).]

2.5.1.11 The Contractor and its providers shall deliver services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity and provide for cultural competency and linguistic needs, including the enrollee prevalent language(s) and sign language interpreters in accordance with 42 C.F.R. §438.206(c).

2.5.1.12 In the event that LDH determines that the Contractor failed to provide one or more MCO covered services, LDH shall direct the Contractor to provide such service. If the Contractor continues to refuse to provide the MCO covered service(s), LDH shall authorize the enrollees to obtain the MCO covered service from another source and shall notify the Contractor in writing that the Contractor shall be charged the actual amount of the cost of such service.

2.5.1.12.1 In such event, the charges to the Contractor shall be obtained by LDH in the form of deductions from the next monthly capitation payment made to the Contractor or a future payment as determined by LDH. With such deductions, LDH shall provide a list of the enrollees for 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.

2.5.1.12.2 In addition to the deduction, the Contractor may be assessed a monetary penalty per incident of non-compliance (see Attachment E, *Table of Monetary Penalties).*

2.5.2 Excluded Services

2.5.2.1 The following services are available to enrollees under the Louisiana State Plan or applicable waivers, but are excluded from this Contract and not provided through the Contractor. The Contractor shall inform enrollees how to access excluded services, provide all required referrals and assist in the coordination of scheduling such services. The Contractor shall implement procedures to coordinate the services it provides to the enrollee with the services the enrollee receives in FFS Medicaid.

2.5.2.1.1 Adult Dental Services with the exception of surgical dental services and emergency dental services;

2.5.2.1.2 Services to individuals in ICF/DDs;

2.5.2.1.3 Personal Care Services for those ages 21 and older;

2.5.2.1.4 Nursing Facility Services, with the exception of post-acute rehabilitative care provided at the discretion of the Contractor when it is cost effective to do so in place of continued inpatient care as an in lieu of service;

2.5.2.1.5 Individualized Education Plan (IEP) Services, including physical therapy, occupational therapy, speech/language therapy, audiology and some psychological therapy, provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures (these services are not provided by OPH certified school-based health clinics);

2.5.2.1.6 All Home & Community-Based Waiver Services;

2.5.2.1.7 Targeted Case Management Services;

2.5.2.1.8 Services provided through LDH's Early-Steps Program (Individuals with Disabilities Education Act (IDEA), Part C Program Services); and

2.5.2.1.9 The following excluded drugs:

2.5.2.1.9.1 Select agents when used for symptomatic relief of cough and colds, not including prescription antihistamine and antihistamine/decongestant combination products;

2.5.2.1.9.2 Select agents when used for anorexia, weight loss, or weight gain, not including orlistat;

2.5.2.1.9.3 Select agents when used to promote fertility, not including vaginal progesterone when used for high-risk pregnancy to prevent premature births;

2.5.2.1.9.4 Drug Efficacy Study Implementation (DESI) drugs;

2.5.2.1.9.5 Select nonprescription drugs, not including OTC antihistamines, antihistamine/decongestant combinations, or polyethylene glycol; and

2.5.2.1.9.6 Narcotics other than those indicated for substance use disorder when treating narcotic addiction.

2.5.3 Prohibited Services

The following services are not Medicaid covered services and shall not be provided to enrollees under this Contract:

2.5.3.1 Elective abortions (those not covered in Attachment A, *MCO Covered Services* and the **MCO Manual**) and related services;

2.5.3.2 Experimental/investigational drugs, procedures or equipment, unless approved by the Secretary of LDH;

2.5.3.3 Elective cosmetic surgery; and

2.5.3.4 Assisted reproductive technology for treatment of infertility.

2.5.4 In Lieu of Services

2.5.4.1 The Contractor may, at its option, cover services or settings for enrollees that are in lieu of MCO covered services if the following conditions are met, as required in 42 C.F.R. §438.3(e)(2)(i)-(iii):

2.5.4.1.1 LDH determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State Plan;

2.5.4.1.2 The enrollee is not required by the Contractor to use the alternative service or setting; and

2.5.4.1.3 The approved in lieu of services are authorized and identified in Attachment B, *In Lieu of Services*.

2.5.4.2 The utilization and actual cost of in lieu of services is taken into account in developing the component of the capitation rates that represents the MCO covered services, unless a statute or regulation explicitly requires otherwise.

2.5.4.3 The Contractor shall submit all in lieu of services for LDH approval in accordance with the **MCO Manual**.

2.5.4.4 The Contractor shall have a plan for identifying and reporting the utilization of in lieu of services to LDH in accordance with the **MCO Manual**. The plan shall be submitted to LDH during readiness reviews and upon any subsequent LDH approval of additional in lieu of services.

2.5.5 Value-Added Benefits

2.5.5.1 As permitted under 42 C.F.R. §438.3(e)(1), the Contractor may offer value-added benefits (VAB) which are not Medicaid covered services or prohibited services. Value-added benefits are provided at the Contractor's expense, are not included in the capitation rate, and shall be identified as value-added benefits in encounter data in accordance with the **MCO Manual**.

2.5.5.2 At a minimum, the Contractor shall offer the VAB proposed in its response to the RFP and agreed upon by LDH, consistent with this Section. Additional VAB may be offered, at the Contractor's option, and shall be reported in accordance with the **MCO Manual**.

2.5.5.3 At the Contractor's discretion, it may provide or assist enrollees with transportation to access a VAB. Encounters for transportation related to VAB shall be identified as such.

2.5.5.4 The Contractor may propose to change the VAB proposed in the Contractor's RFP response on an annual basis as pre-approved in writing by LDH. Additions, deletions or modifications to these VAB shall be submitted to LDH for approval at least six (6) months in advance of the effective date for open enrollment.

2.5.5.5 The VAB proposed in the Contractor's RFP response, and as amended annually, shall be listed in Attachment C, *Value-Added Benefits*.

2.5.5.6 Annually, for the VAB proposed in the Contractor's RFP response, and as amended, the Contractor shall:

2.5.5.6.1 Indicate the PMPM actuarial value of VAB based on enrollment projections for the Contractor's plan, 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

2.5.5.6.2 Include a statement of commitment to provide the VAB for the year.

2.5.5.7 The Contractor shall be directed to revise its proposed PMPM based on any feedback from LDH, following an independent review of any statements of actuarial value provided by the Contractor.

2.5.5.8 The proposed monetary value of value-added benefits shall be considered a binding Contract deliverable. If for any reason, including but not limited to lack of enrollee participation, the aggregated annual PMPM proposed is not expended by the Contractor, LDH reserves the right to require the Contractor to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended.

2.5.5.9 Value-added benefits are not subject to appeal and state fair hearing rights. A denial of these benefits shall not be considered an adverse benefit determination for

purposes of enrollee grievances and appeals. The Contractor shall send the enrollee a notification letter if a value-added benefit is not approved.

2.5.6 Moral or Religious Objections

2.5.6.1 If the Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the Contractor must furnish information about the services that it does not cover, in accordance with 42 U.S.C. §1396u-2(b)(3)(B) and 42 C.F.R. §438.102(b)(1), by notifying:

2.5.6.1.1 LDH with its Proposal, or whenever it adopts the policy during the term of the Contract;

2.5.6.1.2 Potential enrollees before and during enrollment in the MCO;

2.5.6.1.3 Enrollees at least thirty (30) days prior to the effective date of the policy with respect to any particular service; and

2.5.6.1.4 Enrollees through the inclusion of the information in the Member Manual.

2.5.6.2 If the Contractor elects not to provide, reimburse for, or provide coverage of an MCO covered service described in this section because of an objection on moral or religious grounds, the monthly capitation payment for that MCO will be adjusted accordingly.

2.6 Population Health and Social Determinants of Health

The Contractor shall utilize a defined population health approach aligned with the Louisiana Medicaid Managed Care Quality Strategy. A population health approach seeks to maintain and improve the health status of the entire population through prevention, while systematically identifying subpopulations with complex needs and implementing strategies to improve status and reduce health inequities among subpopulations.

The Contractor's population health approach shall engage enrollees across the entire care continuum, promote and incentivize healthy behaviors and disease self-management, address priority social determinants of health (SDOH), which include housing, food insecurity, physical safety, and transportation, integrate care management, and advance evidence-based practices. As part of the population health approach, the Contractor shall evaluate the entire enrollee population, make prevention and wellness programs available to all enrollees, and identify specific enrollees for specific programs based on health needs assessments, data analysis and risk stratification, enrollee self-referral, and provider referral.

The Contractor's population health approach shall be data-driven and built on an understanding of social, economic, familial, cultural, and physical environmental factors and how these relate to the distribution of health conditions, health-related behaviors, and health outcomes among different geographic locations and enrollee groups (e.g., socioeconomic, racial/ethnic, or age) in Louisiana.

2.6.1 Population Health Strategic Plan

2.6.1.1 The Contractor shall develop a Population Health Strategic Plan aligned with the Louisiana Medicaid Managed Care Quality Strategy and submit it to LDH by March 1, 2020. LDH's selected population health priorities as defined in the Louisiana Medicaid Managed Care Quality Strategy, include:

2.6.1.1.1 Reduction of key communicable diseases: HIV, HCV, and syphilis;

2.6.1.1.2 Infant mortality;

2.6.1.1.3 Maternal mortality and morbidity;

2.6.1.1.4 Opioid use disorders;

2.6.1.1.5 Obesity;

2.6.1.1.6 Diabetes;

2.6.1.1.7 Hypertension;

2.6.1.1.8 Cardiovascular disease;

2.6.1.1.9 Tobacco cessation;

2.6.1.1.10 Early childhood health and development, including adverse childhood experiences; and

2.6.1.1.11 Additional prevention and population health management programs to encourage improved health and wellness among enrollees.

2.6.1.2 The Population Health Strategic Plan shall include, at a minimum, the following components:

2.6.1.2.1 Plan for identification of sub-populations within the enrollee population for prevention and population health programs through several mechanisms, which shall include, but not be limited to:

2.6.1.2.1.1 Health Needs Assessments;

2.6.1.2.1.2 Claims analysis and risk scoring;

2.6.1.2.1.3 Provider referral; and,

2.6.1.2.1.4 Enrollee self-referral.

2.6.1.2.2 Plan for measuring population health status and outcomes, including identification of baseline measures and targets for health improvement consistent with quality performance measures specified in Attachment G;

2.6.1.2.3 Identifying health promotion and disease prevention programs based on specific needs of Louisiana's enrollee population;

2.6.1.2.4 Identifying key determinants of disease management and priority health outcomes and strategies for targeted interventions to address these determinants;

2.6.1.2.5 Plan for incorporating community-based health and wellness strategies through promotion of LDH public health programs and linkages and collaborations with community-based agencies;

2.6.1.2.6 Plan for promoting enrollee engagement and input into population health programming; and

2.6.1.2.7 Based on a review of existing community health needs assessments and findings from different regions across the state, including but not limited to those conducted by the Office of Public Health (OPH), a plan for how the Contractor shall work with community-based organizations and/or OPH to address at least one (1) specific initiative, regionally or statewide, to improve the overall health of enrollees in the community and address discrete health inequities and a description of how it will identify and measure the impact of targeted interventions in addressing discrete health inequities experienced by different subpopulations of enrollees.

2.6.1.3 The Contractor shall be responsible for implementing its Population Health Strategic Plan, and shall provide updates to LDH on its implementation during regular Contractor performance reviews and an annual report of its progress on meeting Population Health Strategic Plan goals.

2.6.2 Data Aggregation, Analysis and Dissemination

2.6.2.1 Data Aggregation

2.6.2.1.1 The Contractor shall collect and maintain enrollee self-reported demographic, social determinants, and health needs assessment data for aggregate use in, at a minimum, population health management, network adequacy determination, and quality improvement activities.

2.6.2.1.1.1 Demographic data shall include, but not be limited to, geographic location, age, ethnicity, race, gender identity, sexual orientation, religion, primary language, disability status, and income level.

2.6.2.1.1.2 The Contractor shall use the Health Needs Assessment to survey enrollees for demographic and social determinants data as identified in the Population Health Strategic Plan, with a minimum focus on housing, food insecurity, physical safety, and transportation.

2.6.2.1.2 The Contractor shall incorporate consideration of SDOH into their Population Health Strategic Plan including:

2.6.2.1.2.1 Which social determinants will be assessed including, but not limited to housing, food insecurity, physical safety, and transportation;

2.6.2.1.2.2 The manner in which social determinants data will be collected and analyzed for each enrollee;

2.6.2.1.2.3 The manner in which the social determinants risk determinations are validated;

2.6.2.1.2.4 The timeline and rationale for implementing social determinants data analysis to support population health management; and

2.6.2.1.2.5 The plan for training Contractor staff involved in care management activities on using the social determinants data incorporated into the data analysis.

2.6.2.2 Data Analysis to Support Population Health Management

2.6.2.2.1 The Contractor shall utilize information obtained from the mechanisms described in this section to identify targeted populations for tailored interventions, including:

2.6.2.2.1.1 Subpopulations experiencing a disparate level of needs, including housing, food insecurity, physical safety, and transportation;

2.6.2.2.1.2 Subpopulations demonstrating disparate levels of poor health outcomes or access issues based on factors such as geographic location, age, ethnicity, race, gender identity, sexual orientation, religion, primary language, disability status, and income level; and

2.6.2.2.1.3 Subpopulations of enrollees with Special Health Care Needs.

2.6.2.2.2 Data Analysis Update Requirements

2.6.2.2.2.1 The Contractor shall systematically stratify new enrollees within ninety (90) calendar days of enrollment.

2.6.2.2.2.2 The Contractor shall systematically re-stratify the entire enrollee population on an ongoing basis to ensure enrollees with increasing health risks and social needs are identified for referral for care management and population health management services, with frequency based on case management tier but quarterly at a minimum.

2.6.2.2.2.3 The Contractor shall submit updates to LDH regarding changes to their approach to risk stratification and comprehensive assessment inclusive of health-related social needs and plan to incorporate social determinants into their process for analyzing data to support population health management, noting compliance with respect to

the plan timeline, the plan of correction to realign activities to the timeline, and timeline revisions, if necessary.

2.6.2.3 Data Submission and Data Reporting

2.6.2.3.1 As requested by LDH, the Contractor shall participate in initiatives, which may require collaboration amongst MCOs, to develop, implement within an agreed upon timeframe, and continually improve reports for primary care practices that shall support practice activities to improve population health through case management, including, but not limited to, an actionable list of enrollees assigned to primary care practices that identify the targeted patient populations with identified gaps in care, and enrollees assigned to the PCP who are either not receiving services or are receiving services from different providers.

2.6.2.3.2 As requested by LDH, the Contractor shall participate in initiatives, which may require collaboration amongst MCOs, to develop a core set of SDOH, community-based support service provision, utilization, and health outcomes that providers shall submit for inclusion in performance measure reports, including agreement on how the data must be submitted by providers in order to minimize administrative burden.

2.6.2.3.3 The Contractor shall submit semi-annual updates to LDH and network providers on the effectiveness of its population health and case management initiatives, including at a minimum:

2.6.2.3.3.1 Enrollees with a primary behavioral health diagnosis;

2.6.2.3.3.2 Enrollees experiencing a disparate level of social needs such as housing, food insecurity, physical safety, and transportation; and

2.6.2.3.3.3 Enrollees receiving additional in-person support services such as case management or support from a Community Health Worker, peer specialists, or housing specialists; changes in inpatient hospital utilization, emergency department utilization, physician services and outpatient hospital utilization, residential care utilization; prescription drug utilization; outpatient behavioral health services; and selected health outcomes that are pertinent to the population served.

2.6.3 Addressing Health Disparities

2.6.3.1 General

2.6.3.1.1 The Contractor shall recognize that population health management interventions are designed to address the SDOH, reduce disparities in health outcomes experienced by different subpopulations of enrollees, and ultimately achieve health equity.

2.6.3.1.2 The Contractor shall implement the U.S. Department of Health and Human Services (DHHS) Office of Minority Health (OMH) National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care located at http://www.thinkculturalhealth.hhs.gov/.

2.6.3.2 Services Provided by Community-Based Organizations or the Office of Public Health

2.6.3.2.1 The Contractor shall identify and coordinate with community-based organizations and/or OPH on population health improvement strategies.

2.6.3.2.2 The Contractor shall identify and, to the extent applicable, enter into agreement with community-based organizations and/or OPH to coordinate population health improvement strategies which address socioeconomic, environmental, and/or policy domains; as well as provide services such as care coordination and intensive case management as needed and supported by evidence-based best practices. Agreements shall address the following topics:

2.6.3.2.2.1 Data sharing;

2.6.3.2.2.2 Roles/responsibilities and communication on development of care coordination plans;

2.6.3.2.2.3 Reporting requirements;

2.6.3.2.2.4 Quality assurance and quality improvement coordination;

2.6.3.2.2.5 Plans for coordinating service delivery with primary care providers; and

2.6.3.2.2.6 Payment arrangements.

2.6.3.2.3 The Contractor shall, to the extent applicable, support the design and implementation of an evidence-based Community Health Worker (CHW) program which addresses SDOH, promotes prevention and health education, and is tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience. Examples of CHW services include, but are not limited to:

2.6.3.2.3.1 Pilot a CHW demonstration project serving high-risk enrollees in a target region in Louisiana, if selected by LDH;

2.6.3.2.3.2 Conduct in-person holistic assessments to understand enrollee needs, preferences and socioeconomic barriers;

2.6.3.2.3.3 Assess barriers to healthy living and accessing health care, including conducting home visits;

2.6.3.2.3.4 Schedule medical and behavioral health office visits;

2.6.3.2.3.5 Address barriers to attending visits;

2.6.3.2.3.6 Remind clients of scheduled visits multiple times;

2.6.3.2.3.7 Accompany clients to office visits, as necessary;

2.6.3.2.3.8 Participate in office visits, as necessary;

2.6.3.2.3.9 Advocate for clients with providers;

2.6.3.2.3.10 Arrange for social services (such as housing and heating assistance) and surrounding support services;

2.6.3.2.3.11 Locate clients when they miss appointments, find out why the appointment was missed, and problem-solve to address barriers to care;

2.6.3.2.3.12 Provide social support to help boost clients' morale and sense of self-worth;

2.6.3.2.3.13 Provide clients with training in self-management skills;

2.6.3.2.3.14 Provide clients with someone they can trust by being reliable, non-judgmental, consistent, open, and accepting; and

2.6.3.2.3.15 Serve as a key knowledge source for services and information needed for clients to have healthier, more stable lives.

2.6.3.2.4 The Contractor shall report to LDH, at intervals designated by LDH, on the activities undertaken pursuant to this section of the Contract in a manner determined by LDH.

2.6.3.2.5 The Contractor shall maintain a CHW caseload ratio of at least one (1) full-time CHW per one hundred (100) enrollees enrolled in a CHW program.

2.6.3.2.6 The Contractor shall ensure CHWs share sociodemographic characteristics with enrollees; are adequately equipped to serve enrollees in the community; understand all privacy laws and HIPAA provisions and can demonstrate all core competencies, including:

2.6.3.2.6.1 Cultural mediation;

2.6.3.2.6.2 Provision of culturally appropriate health education and information;

2.6.3.2.6.3 Care coordination, case management and system navigation;

2.6.3.2.6.4 Providing coaching and social support;

2.6.3.2.6.5 Advocating for individuals and communities;

2.6.3.2.6.6 Building individual and community capacity;

2.6.3.2.6.7 Providing direct service;

2.6.3.2.6.8 Implementing individual and community assessments;

2.6.3.2.6.9 Conducting outreach; and

2.6.3.2.6.10 Participating in evaluation and research.

2.6.3.3 Services Provided by State Health Agencies

The Population Health Strategic Plan shall include referral to the following LDH programs as appropriate. The Contractor shall actively support LDH's public health initiatives and coordinate with existing public health programs, including reporting, education, and care management activities. LDH shall maintain a webpage containing centralized resources for the Contractor to use to access population health surveillance data, community needs assessments and core programs they are required to coordinate with. The Contractor shall establish relationships with the LDH programs and create joint-plans to coordinate activities during Year 1 of the Contract or on a time frame otherwise defined by LDH and annually thereafter. The Contractor shall be responsible for ensuring that cooperation exists between each program and its enrollees as applicable and based upon the interest, desires and needs of the enrollee. Activities shall include enrollee and provider education on programs, coordination of referrals including the program, enrollee, provider and Contractor, based on program criteria, data sharing and agreements as needed to accomplish goals and care coordination. The Contractor shall comply with all state and regulatory laws where applicable, including screening and follow up.

LDH programs and initiatives include, but are not limited to, the following:

2.6.3.3.1 Comprehensive reproductive health services, Women, Infants, and Children (WIC), and tobacco cessation;

2.6.3.3.2 Programs, services, and initiatives administered through the State's Title V, Maternal and Child Health Block Grant Program:

- Maternal, Infant, Early Childhood Home Visiting family coaching and support services;
- Louisiana Early Hearing Detection and Intervention Program;
- Newborn Screening Program;
- Developmental Screening Initiative;
- Louisiana Perinatal Quality Collaborative;

- Childhood Lead Poisoning Prevention Program; and
- Children and Youth with Special Health Care Needs Programs.

2.6.3.3.3 Louisiana Commission for the Deaf;

2.6.3.3.4 STD/HIV Program (SHP) Community Based Organizations for individuals with HIV/AIDS;

2.6.3.3.5 Programs to optimize outcomes in individuals with viral hepatitis;

2.6.3.3.6 Disease intervention specialists to support partner notification for STD/HIV, viral hepatitis, and syphilis; and

2.6.3.3.7 OCDD waiver services, EarlySteps and services under the Office of Behavioral Health.

2.6.3.4 The Population Health Strategic Plan shall detail programs specific to enrollee subgroups receiving additional in-person support services such as case management or support from a Community Health Worker or peer specialist. For these services, contractors are encouraged to:

2.6.3.4.1 Use or adapt existing evidence-based CHW programs, that includes work practice manuals for CHWs and supervisors, that is approved by LDH;

2.6.3.4.2 Attest that CHWs share sociodemographic characteristics with enrollees; and

2.6.3.4.3 Ensure that CHWs, supervisors, and program directors successfully complete training on core competencies relevant to their roles.

2.6.3.5 The Contractor shall submit an evaluation plan to LDH for review. Evaluation plans shall include use of a comparison group rather than pre/post analysis and report on metrics such as:

2.6.3.5.1 Changes in inpatient utilization, emergency department utilization, physician services and outpatient utilization, and residential care utilization;

2.6.3.5.2 Prescription drug utilization;

2.6.3.5.3 Outpatient behavioral health services;

2.6.3.5.4 Perceived quality/satisfaction with care;

2.6.3.5.5 Selected health outcomes that are pertinent to the population served; and

2.6.3.5.6 Staff turnover rate.

2.6.4 Health Promotion and Disease Prevention

2.6.4.1 General

2.6.4.1.1 As part of its population health approach, the Contractor shall promote and incentivize through enrollee and provider engagement healthy behaviors, specifically regarding: oral health, sexual health, alcohol and substance use, tobacco use, injury prevention, healthy eating/physical activity, stress, immunization status, and the healthy social and emotional development of children recognizing the importance of safe, stable, nurturing relationships and environments to the prevention of adverse childhood experiences, brain development, and life-long health.

2.6.4.1.2 The Contractor shall provide health promotion and disease prevention services in a manner that is informed by the enrollees' self-identified needs and desires, life experiences and preferences.

2.6.4.1.3 The Contractor shall submit to LDH annually a report on its health promotion and disease prevention programs, including outreach, referral, and follow-up activities related to enrollee uptake and participation rates.

2.6.4.2 Health Promotion and Disease Prevention Services

2.6.4.2.1 The Contractor shall ensure its enrollees have access to evidence-based/best practices educational programs, through Contractor programs or referral to local/state public health and community-based programs, that address risk and improve outcomes.

2.6.4.2.2 Such education and wellness programs shall be available to enrollees through multiple sources, which may include, but are not limited to, websites, social media vehicles, in health care offices and facilities, public schools and through mailings.

2.6.4.2.3 The Contractor shall implement educational, public relation, and social media initiatives to increase enrollee and network provider awareness of public health programs and other community-based resources that are available and designed to reduce the impact of SDOH.

2.6.4.2.4 The Contractor shall collaborate with local/state public health and community-based organizations to facilitate the provision of enrollee health education services to ensure the entire spectrum of SDOH are addressed.

2.6.4.3 Targeted Interventions for Subpopulations Experiencing Health Disparities

2.6.4.3.1 The Contractor shall offer evidence-based practices that have a demonstrated ability to address SDOH and reduce health disparities to all individuals who qualify for those services.

2.6.4.3.2 The Contractor shall collaborate with its high-volume primary care practices to develop, promote and implement targeted evidence-based practice.

2.6.4.3.3 As part of its Population Health Strategic Plan and annual updates, the Contractor shall measure and report semi-annually to LDH on the

effectiveness of its evidence-based interventions to reduce health disparities. Minimum reporting requirements include data on self-reported race, ethnicity, language, housing, food, transportation, employment and safety needs, care management model utilized, risk stratification criteria highlighting priority populations, and targets for engagement and outcomes stratified by priority subgroup in terms of percentage engaged and timing of engagement. For enrollees working with a Community Health Worker, the Contractor shall fulfill requirements outlined within this section.

2.7 Care Management

2.7.1 Comprehensive Care Management Program

The Contractor shall offer a comprehensive care management program to support enrollees, regardless of age, based on an individualized assessment of care needs. At a minimum, care management shall include both the populations and functions described below.

2.7.2 Health Needs Assessment

2.7.2.1 The Contractor shall attempt to conduct enrollee health needs assessments (HNA) as part of the enrollee welcome call to identify health and functional needs of enrollees, and to identify enrollees who require short-term care coordination or case management for medical, behavioral or social needs. Where an enrollee is a child, the HNA shall be completed by the enrollee's parent or legal guardian.

2.7.2.2 The Contractor shall develop, implement, and maintain procedures for completing an initial HNA for each enrollee, and shall make best efforts to complete such screening within ninety (90) calendar days of the enrollee's effective date of enrollment [42 C.F.R. §438.208(b)] and within thirty (30) calendar days of the date of identification for enrollees with special health care needs (SHCN), following the protocol below.

2.7.2.3 If the initial HNA attempt is unsuccessful, subsequent attempts shall be made within the ninety (90) calendar day period or within the thirty (30) calendar day period for enrollees with SHCN. The Contractor shall attempt to conduct, and document its efforts to conduct, the HNA on at least three (3) different occasions, at different times of the day and on different days of the week.

2.7.2.4 The Contractor shall provide HNA data to the enrollee's assigned PCP, and to LDH as requested.

2.7.2.5 The Contractor's HNA shall:

2.7.2.5.1 Utilize a common survey-based instrument, which shall be developed by LDH as described in *Part 3: State Responsibilities*;

2.7.2.5.2 Be made available to enrollees in multiple formats including Web-based, print, and telephone;

2.7.2.5.3 Be conducted with the consent of the enrollee;

2.7.2.5.4 Identify individuals for referral to case management, with more in-depth assessment to occur as part of the individual care planning;

2.7.2.5.5 Screen for needs relevant to priority social determinants of health as described in the *Population Health and Social Determinants of Health*; and

2.7.2.5.6 Include disclosures of how information will be used.

2.7.3 Predictive Modeling

2.7.3.1 The Contractor shall utilize predictive modeling tools to stratify enrollees by risk and identify enrollees who are appropriate for case management. The predictive modeling tool shall consider physical, behavioral and SDOH needs which can be identified through claims, pharmacy, UM and other data, including laboratory results, and supplemented by referrals and HNA results, which may lead an enrollee to be categorized as rising or high risk.

2.7.3.2 The Contractor shall submit as part of readiness reviews a summary of its Predictive Modeling methodology as it is used to help identify enrollees for care management within thirty (30) calendar days of signing the Contract and annually thereafter and prior to any changes.

2.7.4 Enrollees with Special Health Care Needs

The Contractor shall implement mechanisms to comprehensively assess each enrollee identified as having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The Contractor shall offer case management to all enrollees with SHCN regardless of information gathered through this comprehensive assessment, the HNA, or predictive modeling.

2.7.5 Referral to Case Management

2.7.5.1 The Contractor shall receive referrals to case management through the HNA, predictive modeling and individuals with SHCN, as well as referral sources, including but not limited to:

2.7.5.1.1 Enrollee services and self-referral (including enrollee grievances);

2.7.5.1.2 Providers (including primary care, behavioral health and specialist providers); and

2.7.5.1.3 State staff, including Medicaid, OBH, OAAS, OCDD, OPH, and DCFS.

2.7.5.2 The Contractor shall provide guidelines to providers on how and in what circumstances to refer enrollees for potential engagement in case management. The Contractor shall consider all referred enrollees for engagement in case management.

2.7.6 Tiered Case Management Based on Need

The Contractor shall implement a tiered case management program that provides for differing levels of case management based on an individual enrollee's needs. The Contractor shall engage enrollees, or their parent or legal guardian, as appropriate, in a level of case management commensurate with their risk score as identified through predictive modeling combined with the care needs identified in the enrollee's plan of care and HNA, as described below. Where the enrollee's PCP or behavioral health provider offers case management, the Contractor shall support the provider as the lead case manager on the multi-disciplinary care team.

The Contractor shall have three (3) levels of case management and transitional case management for individuals as they move between care settings.

2.7.6.1 Intensive Case Management for High Risk Enrollees (High) (Tier 3)

Enrollees engaged in intensive case management are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH. A plan of care shall be completed in person within thirty (30) calendar days of identification and shall include assessment of the home environment and priority SDOH (see *Population Health and Social Determinants of Health* section). Case management meetings shall occur at least monthly, in person, in the enrollee's preferred setting, or more as required within the enrollee's plan of care, with monthly updates to the plan of care and formal in person re-assessment quarterly. Case management may integrate community health worker support. Attestations of monthly updates to the plan of care and communication of plan of care to the enrollee and the enrollee's primary care provider shall be completed. Case managers serving Tier 3 enrollees shall focus on implementation of the enrollee's plan of care, preventing institutionalization and other adverse outcomes, and supporting the enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an enrollee with primarily behavioral health needs.

2.7.6.2 Case Management (Medium) (Tier 2)

Enrollees engaged in the medium level of case management are typically of rising risk and need focused attention to support their clinical care needs and to address SDOH. A plan of care shall be completed in person within thirty (30) calendar days of identification and include assessment of the home environment and priority SDOH (see *Population Health and Social Determinants of Health* section). Case management meetings shall occur at least monthly, with quarterly updates to the plan of care and formal in-person re-assessment quarterly. Case management may integrate community health worker support. Attestations of quarterly updates to the plan of care and communication of plan of care to the enrollee and the enrollee's primary care provider shall be completed. Case managers serving Tier 2 enrollees shall focus on implementation of the enrollee's plan of care, preventing institutionalization and

other adverse outcomes, and supporting the enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an enrollee with primarily behavioral health needs.

2.7.6.3 Case Management (Low) (Tier 1)

Enrollees engaged in this level of case management are of the lowest level of risk within the case management program and typically require support in care coordination and in addressing SDOH. A plan of care shall be completed in person within ninety (90) calendar days of identification and include assessment of the home environment and priority SDOH (see *Population Health and Social Determinants of Health* section). Case management meetings shall occur at least quarterly, or more as required within the enrollee's plan of care, with annual updates to the plan of care and formal in-person re-assessment annually. Attestations of annual updates to the plan of care and communication of plan of care to the enrollee and the enrollee's primary care provider shall be completed.

2.7.6.4 Transitional Case Management

The Contractor shall implement procedures to coordinate the services that it furnishes to the enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 C.F.R. §438.208(b)(2)(i). The Contractor shall provide transitional case management for enrollees to support transitions between institutional and community care settings, including but not limited to, transitions to/from inpatient hospitals, nursing facilities, psychiatric facilities, PRTFs, therapeutic group homes, permanent supportive housing, intermediate care facilities, residential substance use disorder settings, and transitions out of incarceration.

Transitional case management shall include:

2.7.6.4.1 Development of a transition plan of care in coordination with the care setting, the enrollee and other key members of an enrollee's multi-disciplinary team prior to the transition which is provided in writing to the enrollee upon discharge and includes post discharge care appointments and linkages as appropriate, medication reconciliation, patient education and self-management strategies; addresses prior authorization needs; and a contact person and phone number for the enrollee.

2.7.6.4.2 For enrollees preparing for discharge from a PRTF, TGH, or ICF, aftercare services shall be in place thirty (30) calendar days prior to discharge.

2.7.6.4.3 Ensuring that the setting from which the enrollee is transitioning is sharing information with the enrollee's PCP and behavioral health providers regarding the treatment received and contact information.

2.7.6.4.4 Follow up with enrollees within seventy-two (72) hours following discharge/transition to ensure that services are being provided as detailed within the enrollee's transition plan of care. The plan of care shall identify circumstances in which the follow-up includes a face-to-face visit.

2.7.6.4.5 Additional follow-up as detailed in the discharge plan.

2.7.6.4.6 Coordination across the multi-disciplinary team involved in transitional case management for enrollees.

2.7.6.4.7 For enrollees identified as homeless at the time of care transition, the care management team shall include a housing specialist, as described in the *Individual Plan of Care* subsection, on the multi-disciplinary care team. Housing specialists shall also be used to ensure enrollees transitioning from facility to community are connected to appropriate housing resources, including, but not limited to, referral of potential enrollees to Contractor's Permanent Supportive Housing liaison for application to the Louisiana Permanent Supportive Housing program.

2.7.7 Case Management for Individuals in DOJ Agreement Target Population (Case 3:18-cv-00608, Middle District of Louisiana)

Individuals in the DOJ Agreement Target Population shall be offered transitional case management and Tier 2 or Tier 3 case management, depending upon need. In addition to the case management requirements within this section, the Contractor shall:

2.7.7.1 Ensure access to all medically necessary services covered under the State Plan, including all MCO covered services and those provided through FFS;

2.7.7.2 Survey enrollees within the DOJ Agreement Target Population in the frequency determined by LDH and using LDH-issued tools and methodology; and based on the survey results, work to address any identified issues on an individual level, and if necessary on a systemic level;

2.7.7.3 Report survey data and intervention actions taken or in progress in response to survey findings to LDH;

2.7.7.4 Track and report on enrollee quality indicators, as directed by LDH, which may include, but are not limited to, adverse incidents, physical and mental health and wellbeing, incidence of health crises, stability, community inclusion, and barriers to serving enrollees in the most integrated setting appropriate to their needs; and

2.7.7.5 Meet with LDH transition coordinators as requested by LDH to comply with the requirements of the DOJ Agreement.

2.7.8 Case Management for Individuals in DOJ Agreement Target Population Transitioning from a Nursing Facility

2.7.8.1 Enrollees that are identified for transition from a nursing facility to the community as part of the DOJ Agreement Target Population shall begin to receive transitional case management services prior to release from the nursing facility as part of their discharge planning process. The Contractor shall support the State transition team in the development of the transition plan required as part of the DOJ Agreement.

2.7.8.2 These enrollees shall receive case management services at the Tier 2 or Tier 3 level for a minimum of twelve (12) months post transition, and shall receive face-to-face case management as identified in their individual plan of care. The plan of care shall incorporate recommendations of LDH staff and transition coordinators.

2.7.8.3 The LDH Transition Coordinator shall notify the MCO liaison for the DOJ Agreement of the enrollee's need for transitional case management. The Contractor and its providers shall share information with the LDH Transition Coordinator as needed to effectuate a successful transition.

2.7.9 Independent Evaluations for PASRR Level II

2.7.9.1 The Contractor shall be responsible for conducting PASRR Level II evaluations of enrollees upon referral from LDH. Referrals shall be based upon the need for an independent evaluation to determine the need for nursing facility services and/or the need for specialized services to address mental health issues while the enrollee is in a nursing facility. This evaluation does not include individuals with an OCDD Statement of Approval; there is a separate determination process outside of this Contract for these evaluations.

2.7.9.2 In conducting the evaluation, the Contractor shall follow the criteria set forth in 42 C.F.R. Part 483, Subpart C and shall utilize the PASRR Level II standardized evaluation form provided by LDH.

2.7.9.3 The Contractor shall track enrollees in a nursing facility who went through the PASRR process, those identified with SMI and those receiving specialized services as per 42 C.F.R. §483.130.

2.7.9.4 The Contractor shall track and report quarterly to LDH the delivery of all PASRR specialized behavioral health services as defined and required under 42 C.F.R. §483.120 and the DOJ Agreement.

2.7.10 Individual Plan of Care

2.7.10.1 The Contractor shall develop a comprehensive individualized, person-centered plan of care for all enrollees who are found eligible for case management. Where an enrollee receives services from the Contractor only for behavioral health services, the individualized care plan shall focus on coordination and integration, as appropriate. When an enrollee receives services requiring a plan of care from LDH, such as Home and Community Based Waiver services or services through OPH, there shall be collaboration and coordination among the agencies.

2.7.10.2 Development of the plan of care shall be a person-centered process led by the enrollee's case manager with significant input from the enrollee as well as members of the enrollee's interdisciplinary care team. Where an enrollee receives specialized behavioral health services and has treatment plans developed through their behavioral health providers, the Contractor shall work with the enrollee's behavioral health providers in order to incorporate the treatment plans into the enrollee's overall plan of care and to support the enrollee and the provider in their efforts to implement the treatment plan.

2.7.10.3 The plan of care shall be based on the principles of self-determination and recovery, and shall include all medically necessary services identified by the enrollee's providers as well as the care coordination and other supports to be provided by the Contractor.

2.7.10.4 The plan of care shall be reviewed and revised upon reassessment of functional need. This shall occur at least at the frequency outlined based on the case management tier, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee, their parent or legal guardian, or a member of the multi-disciplinary care team.

2.7.10.5 At a minimum, the plan of care shall include the following elements:

2.7.10.5.1 Identification of the enrollee's treating providers and multi-disciplinary care team if applicable;

2.7.10.5.2 Enrollee's past and present primary care and behavioral health concerns, relevant treatment history including gaps in care, significant medical history, and present health status;

2.7.10.5.3 Enrollee's goals;

2.7.10.5.4 Identified strengths and needs;

2.7.10.5.5 Identified barriers, including priority SDOH, to the care plan goals and how they will be addressed;

2.7.10.5.6 If identified as homeless, access to a housing specialist to connect enrollees to appropriate housing resources;

2.7.10.5.7 Documentation that freedom of choice of services and providers were offered to the enrollee and/or his/her caregiver;

2.7.10.5.8 Supports and services needed to meet the enrollee's needs, including a treatment or service plan for enrollees with SHCN that complies with 42 C.F.R. 438.208(c)(3) and 42 C.F.R. §441.301(c);

2.7.10.5.9 Resources and settings of care recommended to the enrollee's providers, including responsible party and target date for completion;

2.7.10.5.10 Strategies to improve care coordination;

2.7.10.5.11 Strategies to monitor referrals and follow-up for specialty care and routine health care services, including medication management. Each follow-up item includes an identified responsible party(ies);

2.7.10.5.12 Plan for actively linking the enrollee to providers and coordination with medical services, residential, social community, and other support services where needed;

2.7.10.5.13 Plan for addressing crisis to prevent unnecessary hospitalization or institutionalization, including for enrollees with a behavioral health diagnosis who may experience crisis. The crisis plan shall identify resources and contact information; and

2.7.10.5.14 Frequency of case management, type of contact, communication with provider and plan for convening plan of care reviews at intervals consistent with the identified enrollee's care needs and to ensure progress and safety.

2.7.11 Multi-Disciplinary Care Team

2.7.11.1 The Contractor shall identify a multi-disciplinary care team to serve each enrollee based on individual need for all enrollees in case management Tiers 2 and 3 and transitional case management. Contractor shall assign lead case managers based on an enrollee's priority care needs, as identified through the individual care plan. Where behavioral health is an enrollee's primary health issue, the case manager shall be a behavioral health case manager. As needed, case managers with expertise in physical or behavioral health care will support lead case managers where there are secondary diagnoses. If the enrollee is under the age of six (6), the lead case manager shall have expertise in early childhood mental health or access to a consultant with expertise in infant and early childhood mental health.

2.7.11.2 Physical and behavioral health case managers shall be co-located and based in Louisiana to allow for integration of case management for enrollees with both physical and behavioral health care needs. The Contractor may request exceptions to this requirement for individual case managers.

2.7.11.3 In addition to the case manager and the enrollee and their family or authorized representative, the care team shall include members based on an enrollee's specific care needs and goals identified in the individual care plan. The team may change over time as the enrollee's care needs change. Potential team members shall include, but are not limited to:

2.7.11.3.1 Primary care provider;

2.7.11.3.2 Behavioral health provider(s);

2.7.11.3.3 Specialist(s);

2.7.11.3.4 Pharmacist(s);

2.7.11.3.5 Community health worker(s);

2.7.11.3.6 Peer specialist(s);

2.7.11.3.7 Housing specialist, if the enrollee is identified as homeless; and

2.7.11.3.8 State staff, including transition coordinators.

2.7.11.4 Teams shall meet at regular intervals as identified in the individual care plan, based on the individual's care needs. When possible, the team shall meet in person but when necessary, team members may participate in meetings via phone. At a minimum, multi-disciplinary care teams shall meet on a monthly basis for enrollees in Tier 3 case management and on a quarterly basis for enrollees in Tier 2 case management.

2.7.12 Case Management Policies and Procedures

The Contractor shall develop, implement, and maintain criteria and protocols for determining which case management activities may benefit an enrollee. The Contractor shall submit such criteria and protocols to LDH initially as part of the readiness review, on an annual basis thereafter, and prior to any subsequent revisions. Where the Contractor delegates case management to a network provider, the Contractor shall have a written plan in place for monitoring and oversight of performance under any such agreements, including provisions for assessing subcontract compliance and corrective actions and/or termination as appropriate.

The Contractor shall develop, implement, and maintain procedures for providing case management. Case management procedures shall:

2.7.12.1 Be subject to approval by LDH;

2.7.12.2 Include procedures for acquiring and documenting enrollees' consent (or the enrollee's family or authorized representative) to receive case management and for the Contractor to share information about an enrollee's care with enrollees' providers to promote coordination and integration. The Contractor shall make best efforts to obtain such consent;

2.7.12.3 Include a plan describing how management of behavioral health services shall be integrated into the overall care management of the enrollee population;

2.7.12.4 Include criteria and protocols for ensuring appropriate staffing ratios and caseloads for case managers and other staff involved in care management activities in line with industry practices;

2.7.12.5 Include processes for the Contractor to measure the effectiveness and quality of the Contractor's case management procedures. Such processes shall include:

2.7.12.5.1 Frequency and type of case management contact;

2.7.12.5.2 Inclusion criteria for different tiers of case management;

2.7.12.5.3 Expected outcomes in subgroups at different tiers of case management;

2.7.12.5.4 Expected case management penetration and target rate of engagement;

2.7.12.5.5 Identification of relevant measurement processes or outcomes; and

2.7.12.5.6 Use of valid quantitative methods to measure outcomes against performance goals;

2.7.12.6 Include protocols for providing case management activities in a variety of settings, including but not limited to an enrollee's home, shelter, or other care setting;

2.7.12.7 Include criteria and protocols regarding documentation of follow-through with identification and successful linkage to community resources;

2.7.12.8 Include criteria and protocols for discharging enrollees from case management;

2.7.12.9 Ensure that the case management activities each enrollee is receiving are appropriately documented;

2.7.12.10 Ensure regular contacts between case management staff, the enrollee's PCP, the enrollee's primary behavioral health provider, and the enrollee; and

2.7.12.11 Include a process for graduation from Tiers 2 or 3 of case management, as an enrollee's ongoing case management needs are reduced based on the enrollee's plan of care.

2.7.13 Referrals for Tobacco Cessation and Problem Gaming

2.7.13.1 Case managers shall screen for problem gaming and tobacco usage of each enrollee during the initial individual needs assessment. The case manager shall be responsible for advising enrollees that screen positive to quit and will refer the enrollee to appropriate network providers offering tobacco cessation treatment and/or problem gaming services, including the Louisiana Tobacco Quitline.

2.7.13.2 Information regarding treatment services and/or referral to care shall be entered into the Contractor's systems for the purpose of tracking and reporting according to various demographics. Tobacco cessation and problem gaming reports shall be made available upon LDH request in a format and frequency as determined by LDH.

2.7.13.3 The Contractor shall collect and report the information associated with tobacco cessation and/or problem gaming screening, treatment and referral information as appropriate and as specified in the LDH-issued reporting template.

2.7.14 Women, Infant, and Children (WIC) Program Referral

The Contractor shall be responsible for ensuring that coordination exists between the WIC Program and its enrollees. Coordination shall include referral of potentially eligible women, infants and children and reporting of appropriate medical information to the WIC Program.

2.7.15 Permanent Supportive Housing

2.7.15.1 The Contractor shall support the Permanent Supportive Housing program, which is a partnership between LDH and the Louisiana Housing Authority (LHA) to provide deeply affordable, community-integrated housing paired with tenancy supports that assist high-risk persons with disabilities to be successful tenants and maintain stable housing.

2.7.15.2 For the Louisiana PSH program, the Contractor shall:

2.7.15.2.1 Assist potentially eligible enrollees in completing the PSH program application;

2.7.15.2.2 Within one (1) business day of request by designated LDH PSH program staff, provide accurate information about current and past service authorizations and encounters, particularly for behavioral health services such as Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), and Assertive Community Treatment (ACT);

2.7.15.2.3 Ensure timely prior authorization for PSH tenancy and pre-tenancy supports as applicable;

2.7.15.2.4 Ensure PSH tenancy supports are delivered in a timely and effective manner in accordance with an appropriate plan of care;

2.7.15.2.5 Respond timely to service problems identified by PSH program management, including but not limited to those that place an enrollee's/tenant's housing or PSH services at risk; and

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

2.7.15.3 To ensure effective accomplishment of the responsibilities required in this section, the Contractor shall:

2.7.15.3.1 Identify a PSH program liaison, subject to approval by LDH, to work with LDH PSH program staff to ensure effective performance of contract responsibilities and requirements, effective implementation and delivery of PSH services, and to address problems or issues that may arise;

2.7.15.3.2 Assist with statewide targeted outreach to enrollees/households who could benefit from PSH, including those enrollees least likely to apply. The Contractor shall ensure participation of Contractor staff appropriate and

sufficient for effective representation on LDH-convened PSH outreach committee(s); and

2.7.15.3.3 Develop for approval by LDH PSH program staff all required and/or requested written policies and procedures necessary to implement the PSH-related requirements of this Contract. Initial versions of PSH policies and procedures shall be submitted prior to readiness review. PSH program staff will work with the Contractor to ensure consistent policies and procedures across MCOs.

2.8 Continuity of Care

2.8.1 Continuity of Care and Care Transition

2.8.1.1 The Contractor shall develop and maintain effective continuity of care and care transition activities to ensure a continuum of care approach to providing health care services to enrollees. The Contractor shall establish a process to coordinate the delivery of MCO covered services for which it is responsible with services that are provided through FFS, another LDH contractor, or provided by community and social support providers as required by 42 C.F.R. §438.208(b)(2)(iv). The Contractor shall ensure appropriate provider choice within the Contractor's provider network and coordination with out of network providers, as needed for continuity of care. The Contractor shall engage in continuity of care activities to ensure that network providers and Contractor staff are kept informed of the enrollee's treatment needs, changes, progress or problems. The Contractor shall share its activities and processes for continuity of care with LDH through workflows with specific decision points as requested by LDH as part of readiness reviews.

2.8.1.2 The Contractor's continuity of care activities shall provide processes to support effective interactions between enrollees and providers, and to identify and address interactions that are not effective. The Contractor shall monitor service delivery through enrollee surveys, medical and treatment record reviews, and explanation of benefits (EOBs) to identify and overcome barriers to primary and preventive care that an enrollee may encounter. The Contractor shall implement a corrective action plan with its providers on an as needed basis and as determined by LDH.

2.8.1.3 The Contractor shall be responsible for the coordination and continuity of care of health care services for all enrollees consistent with 42 C.F.R. §438.208. In addition, the Contractor shall be responsible for coordinating with the Office for Citizens with Developmental Disabilities for the behavioral health needs of the intellectual/developmental disability (I/DD) co-occurring population.

2.8.1.4 The Contractor shall implement LDH approved continuity of care policies and procedures that meet or exceed the following requirements:

2.8.1.4.1 Ensure that each enrollee has an ongoing source of preventive and primary care appropriate to their needs;

2.8.1.4.2 Ensure each enrollee is provided with information on how to contact the person designated to coordinate the services the enrollee accesses;

2.8.1.4.3 Coordinate care between network PCPs and specialists, including specialized behavioral health providers;

2.8.1.4.4 Coordinate care for out-of-network services, including specialty care services;

2.8.1.4.5 Coordinate Contractor-provided services with services the enrollee may receive from other health care providers;

2.8.1.4.6 Upon request, share with LDH or other health care entities serving the enrollee with special health care needs the results and identification and assessment of that enrollee's needs to prevent duplication of those activities;

2.8.1.4.7 Ensure that each provider furnishing services to the enrollee maintains and shares the enrollee's health record in accordance with professional standards;

2.8.1.4.8 Document authorized referrals in its utilization management system;

2.8.1.4.9 Provide active assistance to enrollees receiving treatment for chronic and acute medical conditions or behavioral health conditions to transition to another provider when their current provider has terminated participation with the Contractor. The Contractor shall provide continuation of such services for up to ninety (90) calendar days or until the enrollee is reasonably transferred without interruption of care, whichever is less; and

2.8.1.4.10 Coordinate with the court system and state child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed. This may include, but is not limited to, attending court proceedings at the request of LDH when there is a need to inform the court of available services and limitations, and participating in cross-agency staffing.

2.8.1.5 The Contractor shall not deny continuation of residential treatment (e.g., TGH or PRTF) for failure to meet medical necessity unless the Contractor can provide the required service through an in-network or out-of-network provider at a lower level of care.

2.8.2 Continuity of Care for Pregnant Women

2.8.2.1 In the event a new enrollee is actively receiving medically necessary covered services in addition to, or other than, prenatal services (see below for new enrollees receiving only prenatal services) at the time of MCO enrollment, the Contractor shall be responsible for the costs of continuation of such medically necessary services, without any form of prior authorization and without regard to whether such services are being provided by contract or non-contract providers. The Contractor shall provide continuation of such services up to ninety (90) calendar days or until the enrollee may be reasonably transferred without disruption, whichever is less. The Contractor may require prior authorization for continuation of the services beyond thirty (30) calendar days; however, the Contractor is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.

2.8.2.2 In the event a new enrollee is in her first trimester of pregnancy and is actively receiving medically necessary covered prenatal care services at the time of MCO enrollment, the Contractor shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of prior authorization and without regard to whether such services are being provided by a contract or non-contract provider until such

time as the Contractor can reasonably transfer the enrollee to a network provider without impeding service delivery that might be harmful to the enrollee's health.

2.8.2.3 In the event a new enrollee is in her second or third trimester of pregnancy and is actively receiving medically-necessary covered prenatal care services at the time of MCO enrollment, the Contractor shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract provider) for sixty (60) calendar days post-partum, provided the enrollee remains covered through Contractor, or referral to a safety net provider if the enrollee's eligibility terminates before the end of the post-partum period.

2.8.2.4 The Contractor shall ensure that the enrollee is held harmless by the provider for the costs of the above medically necessary covered services.

2.8.3 Continuity of Care for Enrollees with Special Health Care Needs

Where a new enrollee is actively receiving medically necessary covered services at the time of MCO enrollment, the Contractor shall provide continuation/coordination of such services up to ninety (90) calendar days or until the enrollee may be reasonably transferred without disruption, whichever is less. The Contractor may require prior authorization for continuation of the services beyond thirty (30) calendar days; however, the Contractor is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.

2.8.4 Continuity of Care for Pharmacy Services

2.8.4.1 The Contractor shall submit for approval, a transition of care program that ensures enrollees can continue treatment of maintenance medications for at least sixty (60) calendar days after enrollment into the MCO or switching from one plan to another. The Contractor shall continue any treatment of antidepressants and antipsychotics for at least ninety (90) calendar days after enrollment into the Contractor's plan. Additionally, an enrollee that is, at the time of enrollment into the MCO, receiving a prescription drug that is not on the PDL shall be permitted to continue to receive that prescription drug if medically necessary for at least sixty (60) calendar days.

2.8.4.2 The Contractor shall continue the behavioral health therapeutic classes (including long-acting injectable antipsychotics) and other medication assisted treatment (including buprenorphine/naloxone and naloxone products) prescribed to the enrollee in a mental health treatment facility for at least ninety (90) calendar days after the facility discharges the enrollee, unless the Contractor's psychiatrist, in consultation and agreement with the facility's prescribing physician, determines that the medications are:

2.8.4.2.1 Not medically necessary; or

2.8.4.2.2 Potentially harmful to the enrollee.

2.8.5 Continuity for Behavioral Health Care

2.8.5.1 The PCP shall provide basic behavioral health services and refer the enrollee(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.

2.8.5.2 The Contractor shall establish policies and procedures to facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs. Principles that guide care integration are as follows:

2.8.5.2.1 Mental illness and addiction are health care issues and shall be integrated into a comprehensive physical and behavioral health care system that includes primary care settings;

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

2.8.5.2.3 The system of care shall be accessible and comprehensive, and shall fully integrate an array of prevention and treatment services for all age groups. It shall be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement; and

2.8.5.2.4 It is important that relevant clinical information is accessible to both the primary care and behavioral health providers consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy.

2.8.5.3 In any instance when the enrollee presents to the network provider, including calling the MCO's toll-free number listed on the member's ID card, and an enrollee is in need of emergency behavioral health services, the Contractor shall instruct the enrollee to seek help from the nearest emergency medical provider. The Contractor shall initiate follow-up with the enrollee within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.

2.8.5.4 The Contractor shall comply with all post-stabilization care service requirements found at 42 C.F.R. §438.114.

2.8.5.5 The Contractor shall include documentation in the enrollee's medical record that attempts are made to engage the enrollee's cooperation and permission to coordinate the enrollee's over-all care plan with the enrollee's behavioral health and primary care provider.

2.8.5.6 The Contractor shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity of care.

2.8.5.7 These procedures shall address enrollees with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services.

2.8.5.8 The Contractor shall provide or arrange for training of providers and other individuals involved in care management activities on identification and screening of behavioral health conditions and referral procedures.

2.8.6 Continuity for DME, Prosthetics, Orthotics, and Certain Supplies

2.8.6.1 In the event a Medicaid enrollee entering the MCO is actively receiving Medicaid covered durable medical equipment, prosthetics, orthotics, and certain supplies services at the time of MCO enrollment, whether such services were provided by another MCO or Medicaid FFS, the Contractor shall be responsible for the costs of continuation of these services, without any form of prior authorization and without regard to whether such services are being provided by contract or non-contract providers. The Contractor shall provide continuation of such services for up to ninety (90) calendar days **or** until the enrollee may be reasonably transferred (within the timeframe specified in this Contract) without disruption, whichever is less.

2.8.6.2 The Contractor shall also honor any prior authorization for durable medical equipment, prosthetics, orthotics and certain supplies services issued while the enrollee was enrolled in another MCO or the Medicaid FFS program for a period of ninety (90) calendar days after the enrollee's enrollment in the MCO.

2.8.7 Transitioning Between MCOs or to FFS

2.8.7.1 The Contractor shall provide active assistance to enrollees when transitioning to another MCO or to Medicaid FFS.

2.8.7.2 The receiving MCO shall be responsible for the provision of medically necessary services covered under the Contract that are required for the enrollee during the transition period (i.e. prenatal care, acute care, etc.). The transition period shall not exceed thirty (30) calendar days from the effective date of the enrollee's enrollment in the receiving MCO unless the enrollee has been identified as an individual with special health care needs (See *Care Management* section for exceptions for individuals with Special Health Care Needs.) During this transition period, the receiving MCO shall be responsible for, but not limited to, notification to the new PCP of the enrollee's selection, initiation of the request of transfer for the enrollee's medical files, arrangement of medically necessary services (if applicable) and all other requirements for new enrollees.

2.8.7.3 If an enrollee is to be transferred between MCOs but is hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving MCO. However, the relinquishing MCO is responsible for the enrollee's hospitalization until the enrollee is discharged. The receiving MCO is responsible for all other care.

2.8.7.3.1 In the event that the relinquishing MCO's contract is terminated prior to the enrollee's discharge, responsibility for the remainder of the hospitalization charges shall revert to the receiving MCO, effective at 12:01 a.m. on the day after the relinquishing MCO's contract ends. LDH will identify and address any exceptions to this provision in the **MCO Manual**.

2.8.7.4 Upon notification of the enrollee's transfer, the receiving MCO shall request copies of the enrollee's medical record, unless the enrollee has arranged for the transfer. The previous provider shall transfer a copy of the enrollee's complete medical record and allow the receiving MCO access (immediately upon request) to all medical information necessary for the care of that enrollee. Transfer of records shall not interfere or cause delay in the provision of services to the enrollee. The cost of reproducing and forwarding medical records to the receiving MCO shall be the responsibility of the relinquishing MCO. A copy of the enrollee's medical record and supporting documentation shall be forwarded by the relinquishing MCO's PCP within ten (10) business days of the receiving MCO's PCP's request.

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

2.8.7.4.2 During transition, the Contractor is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider.

2.8.7.5 Appropriate medical records and case management files of the transitioning enrollee shall also be transmitted. The cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor.

2.8.7.6 Special consideration shall be given to, but not limited to, the following:

2.8.7.6.1 Enrollees with significant conditions or treatments such as enteral feedings, oxygen, wound care, and ventilators, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition;

2.8.7.6.2 Enrollees who have received prior authorization for services such as scheduled surgeries, post-surgical follow up visits, therapies to be provided after transition or out-of-area specialty services;

2.8.7.6.3 Enrollees who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and enrollees who were in the NICU after birth; and

2.8.7.6.4 Enrollees with significant medical conditions such as a high-risk pregnancy or pregnancy within the last thirty (30) days, the need for organ or tissue transplantation, or chronic illness resulting in hospitalization.

2.8.7.7 When relinquishing enrollees, the MCO is responsible for timely notification to the receiving MCO regarding pertinent information related to any special needs of transitioning enrollees. The MCO, when receiving a transitioning enrollee with special needs, is responsible for coordinating care with the relinquishing MCO so services are

not interrupted, and for providing the new enrollee with MCO and service information, emergency numbers and instructions on how to obtain services.

2.9 Provider Network, Contracts, and Related Responsibilities

2.9.1 General Provider Network Requirements

2.9.1.1 The Contractor shall provide or ensure the provision of all MCO covered services specified in this Contract. Availability and accessibility of MCO covered services, including geographic access, and appointment and wait times for enrollees shall be in accordance with the access and network adequacy standards set forth in the applicable federal regulations and this Contract, including, but not limited to, requirements set forth in Attachment D, *Provider Network Standards*.

2.9.1.2 The Contractor shall give assurances to LDH and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in accordance with LDH's standards for access to care, including the standards at 42 C.F.R. §438.68 and §438.206 and the access to care standards in Attachment D during readiness reviews, on an annual basis, and at any time there has been a material change in the Contractor's operations that would affect the adequacy of capacity and services. The Contractor's supporting documentation shall be in compliance with the **MCO Manual** and demonstrate that it:

2.9.1.2.1 Offers an appropriate range of preventive, primary care, and specialty services, including behavioral health specialty services, that is adequate for the anticipated number of enrollees; and

2.9.1.2.2 Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees.

2.9.1.3 To demonstrate accessibility and availability of MCO covered services, the Contractor shall comply with all applicable reporting requirements. These minimum requirements shall not release the Contractor from the requirement to provide or arrange for the provision of any medically necessary MCO covered service required by its enrollees.

2.9.2 Availability and Furnishing of MCO Covered Services

2.9.2.1 The Contractor shall maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services covered under this Contract for all enrollees, including those with limited English proficiency, physical or behavioral health disabilities. [42 C.F.R. §438.206(b)(1)]

2.9.2.2 The Contractor shall ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or behavioral health disabilities [42 C.F.R. §438.206(c)(3)].

2.9.2.3 If the Contractor is unable to provide the necessary services to an enrollee within their network, the Contractor shall adequately and timely cover these services out of network for the enrollee for as long as the Contractor's provider network is unable to provide the services. The Contractor shall ensure coordination with respect to authorization and payment issues in these circumstances to ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network [42 C.F.R. §438.206(b)(4) and (5)].

2.9.2.4 The Contractor shall ensure parity in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in accordance with 42 C.F.R. §438.910(d)(3).

2.9.3 Timely Access to Care

2.9.3.1 The Contractor shall meet and require its network providers to meet LDH standards for timely access to care and services as specified in this Contract, taking into account the urgency of the need for services [42 C.F.R. §438.206(c)(1)(i)].

2.9.3.2 The Contractor shall ensure that the network providers offer hours of operation to its enrollees that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees [42 C.F.R. §438.206(c)(1)(ii)]. The Contractor shall regularly disseminate appointment standards and procedures to its providers and enrollees and include this information on the Contractor's provider website. The Contractor must include the applicable appointment accessibility standards from Attachment D in its provider agreements, either directly or through reference to the Contractor's Provider Manual.

2.9.3.3 The Contractor shall make services included in the Contract available twenty-four (24) hours a day, seven (7) days a week, when medically necessary [42 C.F.R. §438.206(c)(1)(iii)].

2.9.3.4 The Contractor shall educate providers on the appointment accessibility standards of this Contract, evaluate provider compliance with these standards, and ensure that appointments with qualified providers are available to enrollees on a timely basis.

2.9.3.5 The Contractor shall establish mechanisms to ensure compliance with access requirements by network providers and shall monitor network providers regularly to determine compliance and shall take corrective action if there is a failure to comply by a network provider [42 C.F.R. §438.206(c)(1)].

2.9.4 Geographic Access Requirements

2.9.4.1 The Contractor shall develop and maintain a provider network that, at a minimum, complies with travel time, distance requirements, and provider to enrollee ratios specified in this Contract. These minimum geographic access requirements for the provider network shall not release the Contractor from the requirement to provide or arrange for the provision of any medically necessary MCO covered service required

by its enrollees within LDH standards for timely access to care and services, taking into account the urgency of the need for services. If the Contractor or LDH identifies or anticipates that the network will not be sufficient to meet the timely access to care standards of this Contract for an MCO covered service in any location or for any population of enrollees, the Contractor shall enhance its provider network in order to meet such state standards.

2.9.4.2 In assessing network adequacy and compliance with this Contract, the Contractor shall identify, take into consideration, and separately report on provider specialists with limited provider agreements such as single case agreements and those that preclude enrollee access to appointments outside of hospital settings.

2.9.5 Out-of-Network Protocols

2.9.5.1 The Contractor shall maintain and utilize protocols to address situations when the provider network is unable to provide an enrollee with appropriate access to MCO covered services as defined in this Contract and the **MCO Manual**. The Contractor's protocols shall ensure, at a minimum, the following:

2.9.5.1.1 If the Contractor is unable to provide a particular MCO covered service through a network provider, it will be adequately covered in a timely manner out-of-network;

2.9.5.1.2 That the particular service will be provided by a qualified and clinically appropriate provider;

2.9.5.1.3 That the provider shall be located within the shortest travel time of the Enrollee's residence, taking into account the availability of public transportation to the location;

2.9.5.1.4 That the provider is licensed by the state of Louisiana or, if located in another state, the provider is licensed by that state; and

2.9.5.1.5 That the provider is licensed and accredited by a LDH approved accrediting organization, if required by Louisiana state or federal requirements.

2.9.6 Requests for Exceptions to Access Requirements

2.9.6.1 The Contractor shall ensure PCP services, OB/GYN, hospital services, pharmacy, behavioral health and other services identified in the Contract and the **MCO Manual** are available from network providers within the specified travel distance and time requirements from the enrollee's home. Exceptions, if any, to these time and distance standards shall be at the discretion of LDH and only considered based on the prevailing community standard.

2.9.6.2 The Contractor must submit any requests for exceptions for time, distance or appointment accessibility standards in writing to LDH for approval. Such requests must be in a format specified by LDH and include data on the local provider population available to the non-Medicaid population.

2.9.6.3 If LDH grants the Contractor an exception to a time or distance or appointment accessibility standard:

2.9.6.3.1 The exception is limited to the identified provider type and parish or parishes and is granted for a period of up to one (1) year, at which point the Contractor may submit a new request.

2.9.6.3.2 The Contractor shall monitor enrollee access to the specific provider type on an ongoing basis and provide the findings to LDH as part of its Network Development and Management Plan. Specifically, the Contractor shall:

2.9.6.3.2.1 Describe how it shall reasonably deliver MCO covered services to enrollees who may be affected by the exception and how it will work to increase access to the provider type in the designated parish or parishes; and

2.9.6.3.2.2 Monitor, track, and report to LDH on the delivery of MCO covered services to enrollees potentially affected by the exception.

2.9.6.4 The Contractor shall allow an enrollee the option of choosing to travel further than established access standards in order to access a preferred provider. The enrollee shall be responsible for travel arrangements and costs unless there is not a qualified provider meeting the accessibility standards within the Contractor's provider network.

2.9.6.5 As permitted by state law, telemedicine may be used to facilitate access to MCO covered services by licensed professionals to augment the Contractor's network. Any service provided via telemedicine must be medically necessary, and the procedure individualized, specific, and consistent with symptoms or confirmed diagnosis of an illness or injury under treatment, and not in excess of the enrollee's needs.

2.9.7 Overall Network Management

The Contractor shall develop and implement a strategy to manage the provider network with a focus on timely access to services for enrollees, quality, consistent practice patterns, the principles of rehabilitation and recovery for behavioral health services, cultural and linguistic competence, and cost effectiveness.

2.9.7.1 The Contractor's network management strategy shall include at a minimum:

2.9.7.1.1 A system for utilizing network provider profiling and benchmarking data to identify and manage outliers;

2.9.7.1.2 A system for the Contractor and network providers to identify and establish improvement goals and periodic measurements to track network providers' progress toward those improvement goals; and

2.9.7.1.3 Conducting on-site visits to network providers for quality management and quality improvement purposes.

2.9.7.2 The Contractor must conduct profiling activities for PCPs, behavioral health providers and facilities, and other provider types as directed by LDH. The Contractor must describe the methodology it uses to identify which and how many providers to profile and to identify measures to use for profiling such providers.

2.9.7.3 The Contractor shall use the results of its provider profiling activities to identify areas of improvement for providers, and/or groups of providers and establish provider-specific quality improvement goals for priority areas in which a provider(s) does not meet established Contractor standards or improvement goals;

2.9.7.4 The Contractor shall monitor and enforce access and other network standards required by this Contract and take appropriate action with providers whose performance is in need of improvement or out of compliance with this Contract, including when a provider fails to meet minimum provider qualifications or requirements, or appointment availability standards; and

2.9.7.5 The Contractor shall make collected information, monitoring reviews and findings, corrective action plans and follow-up related to provider network management available to LDH upon request. At LDH's direction, the Contractor shall modify its network management strategy, tools, and processes to comply with the Contract and the **MCO Manual**.

2.9.8 Provider Enrollment

2.9.8.1 Provider Participation

2.9.8.1.1 In accordance with 42 C.F.R. §438.602(b) and upon LDH implementation of a provider management system, the Contractor and its subcontractors shall not enter into a network provider agreement with a provider to provide services to Medicaid beneficiaries or reimburse a claim containing a provider's NPI when the provider is not otherwise appropriately screened by and enrolled with the State according to the standards under 42 C.F.R. Part 455, Subparts B and E. Such enrollment includes providers that order, refer, or furnish services under the State Plan and Waivers. Such enrollment does not obligate providers to participate in the FFS healthcare delivery system.

2.9.8.1.2 When LDH implements a National Committee for Quality Assurance (NCQA)-certified Credentials Verification Organization (CVO), the Contractor shall participate on the CVO credentialing committee and accept the final credentialing decisions of the CVO.

2.9.8.1.3 The Contractor 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 Contractor shall terminate such network provider immediately and notify affected enrollees in writing that the provider is no longer participating in the network.

2.9.8.1.4 Prior to contracting with a network provider and/or paying a provider's claim, the Contractor 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, CHIP, and/or any other government healthcare program and has obtained a Medicaid provider number from LDH upon implementation of appropriate systems. The Contractor may use the CVO's verifications to ensure compliance with these standards.

2.9.8.1.5 The Contractor shall comply timely with all non-compliance actions imposed by the State on network providers, including enrollment revocation, termination, and exclusions.

2.9.8.1.6 For the following qualified providers, the Contractor shall offer a provider agreement and also have LDH's approval prior to terminating the agreements:

- Louisiana Office of Public Health (OPH);
- All OPH-certified School Based Health Clinics (SBHCs);
- All small rural hospitals meeting the definition in the Rural Hospital Preservation Act;
- Federally Qualified Health Centers (FQHCs);
- Rural Health Clinics (RHCs) (free-standing and hospital based);
- Clinics and outpatient providers funded under the HRSA administered Ryan White HIV/AIDS Program;
- OPH Family Planning clinics and providers, including those funded by Title X of the Public Health Services Act;
- All providers approved by the LDH PSH program to provide tenancy and pre-tenancy supports for the Louisiana Permanent Supportive Housing program; and
- Local Governing Entities.

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

2.9.8.1.8 Notwithstanding the requirements of this Section, the Contractor may limit provider participation to the extent necessary to meet the needs of the

Contractor's enrollees. These provisions also do not interfere with measures established by the Contractor to control costs and quality consistent with its responsibilities under this Contract nor does it preclude the Contractor from using different reimbursement amounts, which may be greater than the published Medicaid fee schedule, for different specialists or for different practitioners in the same specialty [42 C.F.R. §438.12(b)].

2.9.8.1.9 If the Contractor declines requests of individuals or groups of providers to be included in its provider network, the Contractor shall give the affected providers written notice of the reason for its decision within fourteen (14) calendar days of its decision [42 C.F.R. §438.12(a)(1)].

2.9.8.2 Exclusion from Participation

2.9.8.2.1 The Contractor 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 42 U.S.C. §1320a-7 or §1320a-7a [42 C.F.R. §438.214(d)] or state funded health care programs. The Contractor may access a list of providers excluded from federally funded health care programs using the sources provided in the **MCO Manual**.

2.9.8.2.2 The Contractor shall not contract or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to 42 U.S.C. §1320a-7 or 42 U.S.C. §1320c-5 or who are otherwise barred from participation in the Medicaid and/or Medicare program. This includes providers currently undergoing any of the following conditions identified through LDH proceedings:

2.9.8.2.2.1 Revocation of the provider's license;

2.9.8.2.2.2 Exclusion from the Medicaid program;

2.9.8.2.2.3 Termination from the Medicaid program;

2.9.8.2.2.4 Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and Utilization Review Subsystems (SURS) Rule (LAC 50:I.Chapter 41);

2.9.8.2.2.5 Provider fails to timely renew its license; or

2.9.8.2.2.6 The Louisiana Attorney General's Office has seized the assets of the service provider.

2.9.8.2.3 The Contractor shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

2.9.8.2.4 The Contractor shall not remit payment for services provided under this contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories.

2.9.8.3 Other Enrollment and Disenrollment Requirements

2.9.8.3.1 The Contractor shall not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that licensure or certification. If the Contractor declines to include individual or groups of providers in its provider network, it shall give the affected providers written notice of the reason for its decision. [42 C.F.R. §438.12(a)(1)].

2.9.8.3.2 The Contractor shall establish and follow a documented process for credentialing and re-credentialing of network providers [42 C.F.R. §438.12(a)(2) and §438.214]. In addition, the Contractor shall not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 C.F.R. §438.214(c)].

2.9.8.3.3 The Contractor shall require that all providers be in compliance with Americans with Disabilities Act (ADA) requirements and provide physical access for Medicaid enrollees with disabilities.

2.9.8.3.4 If the Contractor terminates a provider agreement for cause, the Contractor shall provide written notice to the provider within one (1) business day of the decision being made. The notice shall be sent at least fifteen (15) days prior to the effective date of termination via electronic means and via certified mail within one (1) business day of the decision being made. The Contractor shall notify LDH through email prior to provider notification. The termination shall be immediate if the termination is pursuant to La. R.S. 46:460.73(B) or due to the loss of required license.

2.9.8.3.5 The Contractor shall notify LDH when the Contractor or its subcontractor terminates a provider agreement for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

2.9.8.3.6 The Contractor should limit the termination of provider agreements without cause to coincide with the annual open enrollment period. If the Contractor terminates a provider agreement without cause outside of the open enrollment period, the Contractor shall be responsible for the following:

2.9.8.3.6.1 Identifying and providing to LDH an accounting of all members who have received services from the impacted provider within the past twelve (12) months by, at minimum, claims analysis and PCP selection;

2.9.8.3.6.2 Developing a letter, to be approved by LDH, informing members of the termination and their ability to change their MCO which shall be mailed to each impacted member along with a pre-paid return envelope;

2.9.8.3.6.3 Receiving and inputting in the member enrollment web-based system enrollee disenrollment requests resulting from the termination; and

2.9.8.3.6.4 The administrative cost borne by LDH for enrollee disenrollments resulting from the termination, as invoiced by LDH.

2.9.8.3.7 The Contractor shall receive written approval from LDH prior to terminating a provider agreement without cause when the provider is located in a Health Professional Shortage Area (HPSA).

2.9.8.3.8 When a provider agreement is terminated, with or without cause, the Contractor shall send LDH a file that identifies the enrollees impacted by the termination. The Contractor shall also provide to LDH its plan to notify the Contractor's enrollees of such change, its strategy to ensure timely access for enrollees through different in-network and/or out-of-network providers, and its plan for ensuring that there will be no stoppage or interruption of services to enrollees.

2.9.8.3.9 The Contractor shall provide the notice of provider termination within fifteen (15) calendar days after receipt or issuance of the termination notice, in accordance with 42 C.F.R. §438.10(f)(1), and no less than sixty (60) calendar days before the effective date of the termination to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider within the past two (2) years. LDH reserves the right to waive the sixty (60) day notification requirement in the event that a for-cause provider termination poses harm to the health or welfare of enrollees.

2.9.8.3.10 The Contractor shall notify the State's provider management contractor by close of business the next business day of a network provider's termination.

2.9.9 Mainstreaming

2.9.9.1 LDH considers mainstreaming of enrollees into the broader health delivery system to be important. The Contractor shall ensure that all network providers accept enrollees for treatment and that network providers do not intentionally segregate enrollees in any way from other persons receiving services.

2.9.9.2 To ensure mainstreaming of enrollees, the Contractor shall take affirmative action to confirm that enrollees are provided MCO covered services without regard to race, color, creed, sex, gender identity, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical, behavioral, or cognitive disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

2.9.9.2.1 Denying or not providing to an enrollee any medically necessary MCO covered service or availability of a facility; and

2.9.9.2.2 Discriminatory practices with regard to enrollees such as separate waiting rooms, separate appointment days, separate physical locations, or preference to private pay or Medicaid FFS patients.

2.9.9.3 When the Contractor becomes aware of a network provider's failure to comply with mainstreaming, the Contractor shall develop a written plan for coming into compliance with the Contract requirement for mainstreaming with the network provider within thirty (30) calendar days and notify LDH in writing.

2.9.9.4 The Contractor shall ensure that providers do not exclude treatment or placement of enrollees for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.

2.9.10 Primary Care

The PCP shall serve as the enrollee's initial and most important point of interaction with the Contractor's provider network. A PCP shall be an individual physician, nurse practitioner, or physician assistant who accepts primary responsibility for the management of an enrollee's health care. The primary care provider is the enrollee's point of access for preventive care or an illness and may treat the enrollee directly, refer the enrollee to a specialist (secondary/tertiary care), or admit the enrollee to a hospital.

2.9.10.1 PCP Selection

The Contractor shall:

2.9.10.1.1 Allow each enrollee to choose his or her PCP and other health care professionals to the extent possible and appropriate;

2.9.10.1.2 Make best efforts to assist and encourage each enrollee to select a PCP. Such best efforts shall include, but not be limited to, providing interpreter services when necessary to assist the enrollee in choosing a PCP, making efforts to contact those enrollees who have not contacted the Contractor and, in the case of children in the care or custody of DCFS, making efforts to contact the child's state caseworker through the LDH appointed DCFS liaison; and

2.9.10.1.3 Assist enrollees in selecting a PCP, within fifteen (15) calendar days after their effective date of enrollment, by eliciting information on prior PCP affiliations that the enrollee may have had and providing the enrollee with relevant information on adult or pediatric PCPs in close proximity to the enrollee, including providing information regarding the experience of the PCP in treating special populations if known to be applicable.

2.9.10.2 PCP Automatic Assignment

2.9.10.2.1 The Contractor is responsible for developing a PCP automatic assignment methodology in collaboration with LDH to assign to a PCP an enrollee for whom the Contractor is the primary payor when the enrollee:

2.9.10.2.1.1 Does not make a PCP selection;

2.9.10.2.1.2 Selects a PCP within the network that has reached its maximum physician/patient ratio;

2.9.10.2.1.3 Selects a PCP within the network that has restrictions/limitations (e.g. pediatric only practice); or

2.9.10.2.1.4 Does not make a selection of a PCP for a newborn within fourteen (14) calendar days of birth.

2.9.10.2.2 In the event that the enrollee has not selected a PCP and the Contractor is unable to elicit a PCP selection from an enrollee, the Contractor shall promptly assign a PCP to each such enrollee as described below. The assignment shall be to the most appropriate PCP in accordance with this Contract, the **MCO Manual**, and the Contractor's approved automatic assignment methodology. The PCP assignment shall be effective no later than fifteen (15) calendar days after the effective date of enrollment with the Contractor. For a newborn, the PCP assignment shall be effective no later than the first month of enrollment subsequent to the birth of the child.

2.9.10.2.3 The Contractor's PCP automatic assignment methodology shall be subject to LDH approval as part of readiness reviews and fifteen (15) calendar days prior to any subsequent changes in the Contractor's assignment methodology unless otherwise agreed to by LDH. The Contractor shall make its PCP assignment methodology readily available to LDH and via the Contractor's website, provider handbook, and enrollee handbook and upon request.

2.9.10.3 PCP Designation for Enrollees

2.9.10.3.1 If a new enrollee has informed the enrollment broker of a PCP selection, the name of the PCP requested by the enrollee will be included in the enrollee file from the enrollment broker to the Contractor. The Contractor shall confirm the PCP selection information received in the Enrollee File in a written notice to the enrollee within ten (10) business days of receiving the file.

2.9.10.3.2 For any enrollee who has not yet selected or been assigned a PCP, the Contractor shall, within three (3) business days after receiving notification that such enrollee seeks to or has obtained care, in or out of the provider network, contact the enrollee and assist the enrollee in choosing a PCP. If the Contractor is unable to reach the enrollee, then the Contractor shall assign a PCP to such enrollee and affirmatively notify the enrollee and the PCP of the assignment as required in this Contract.

2.9.10.3.3 At least monthly, the Contractor shall share complete lists of designated enrollees with PCPs. The Contractor shall have a process, not to exceed ten (10) business days, by which a PCP may dispute the Contractor's assignment policies or the assignment of an individual enrollee. The Contractor shall submit its dispute process for LDH approval.

2.9.10.3.4 The Contractor shall be responsible for providing to the enrollment broker, information on the number of enrollees in each PCP panel and remaining capacity of each individual PCP on a quarterly basis. The Contractor shall submit a file listing for each PCP the individual enrollees that are designated, via selection or automatic assignment, to that PCP's panel to LDH weekly as described in the **MCO Manual.**

2.9.10.3.5 The Contractor shall:

2.9.10.3.5.1 Monitor, on an ongoing basis, the completeness and accuracy of the PCP designations for all enrollees.

2.9.10.3.5.2 Annually, and at other frequencies specified by LDH, audit PCP designations for enrollees to identify enrollees with no PCP designation or an incorrect PCP designation;

2.9.10.3.5.3 Take steps to rectify identified errors and gaps in PCP designations, such as through reconciliation of information provided by the enrollee, the PCP, and/or the Contractor's records, and facilitation of enrollee selection of a PCP, or assignment of enrollees to PCPs;

2.9.10.3.5.4 Conduct root cause analyses, and implement activities to maximize proactively the completeness and accuracy of PCP designations;

2.9.10.3.5.5 Annually, and at other frequencies specified by LDH, assess its PCP assignment methodology by conducting a claims/encounter-based analysis utilizing available historical information about enrollee use of health care services to identify which providers and primary care services the enrollees used over a period of time, and consider providers that have billed for evaluation and management codes, including those for wellness care. Based on this analysis the Contractor shall offer to change PCPs for individual enrollees and shall consider changes to its PCP assignment methodology to improve care and case management; and

2.9.10.3.5.6 Annually submit to LDH an Enrollee-PCP assignment report in a format and frequency to be specified by LDH, such report shall include results of the Contractor's enrollee-PCP assignment monitoring efforts and the actions taken by the Contractor in the prior twelve (12) months.

2.9.10.4 PCP Transfers

The Contractor shall:

2.9.10.4.1 Allow an enrollee to change PCPs, at least once, during the first ninety (90) calendar days from the enrollee's selection of or assignment to a PCP without cause and shall allow such a PCP transfer request to go in effect immediately;

2.9.10.4.2 At the enrollee's request, allow the enrollee to change his or her PCP with cause at any time and allow for enrollment with the new PCP to be effective immediately;

2.9.10.4.3 Have written policies and procedures for allowing enrollees to select a new PCP and provide information to enrollees on options for selecting a new PCP for cause; and

2.9.10.4.4 Define what is considered as cause in written policies and include, but not be limited to, when an enrollee has moved, a PCP is non-compliant with provider standards or is terminated from the Contractor, or when a PCP change is ordered as part of the resolution to a grievance proceeding.

2.9.10.5 PCP Responsibilities

2.9.10.5.1 The Contractor shall ensure that network PCPs fulfill their responsibilities including, but not limited to, the following:

2.9.10.5.1.1 Managing and coordinating the medical and behavioral health care needs of enrollees to ensure that all medically necessary services are made available in a timely manner;

2.9.10.5.1.2 Referring patients to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available;

2.9.10.5.1.3 Communicating with all other levels of medical care to coordinate, and follow up the care of individual patients;

2.9.10.5.1.4 Providing the coordination necessary for the referral of patients to specialists;

2.9.10.5.1.5 Maintaining a medical record of all services rendered by the PCP and a record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow up and/or coordination of care;

2.9.10.5.1.6 Development of plans of care to address risks and medical needs and other responsibilities as defined in this section;

2.9.10.5.1.7 Ensuring that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements

in 45 C.F.R. Parts 160 and 164 and all state statutes. 45 C.F.R. Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information;

2.9.10.5.1.8 Providing after-hours availability to patients who need medical advice. At a minimum, the PCP office shall have a return call system staffed and monitored in order to ensure that the enrollee is connected to a designated medical practitioner within thirty (30) minutes of the call;

2.9.10.5.1.9 Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at a Contractor participating hospital;

2.9.10.5.1.10 Working with Contractor case managers to develop plans of care for enrollees receiving case management services;

2.9.10.5.1.11 Participating in the Contractor's case management team, as applicable and medically necessary; and

2.9.10.5.1.12 Conducting screens for common behavioral issues, including, but not limited to, depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, early detection, identification of developmental disorders/delays, social-emotional health, and SDOH to determine whether the enrollee needs behavioral health services.

2.9.10.5.2 The Contractor shall seek to contract with adult and pediatric PCPs that offer extended primary care hours and shall review adult and pediatric primary care, urgent care and emergency department (ED) utilization patterns across different regions and parishes to assess access to care.

2.9.10.5.3 At least annually, according to a format specified by LDH, the Contractor shall:

2.9.10.5.3.1 Report on the number and percentage of adult PCPs with extended primary care hours (nights and weekends) that are not closed to new patients;

2.9.10.5.3.2 Report on the number and percentage of pediatric PCPs with extended primary care hours (nights and weekends) that are not closed to new patients; and

2.9.10.5.3.3 Review primary care, urgent care and ED utilization patterns to identify regions and parishes that appear to have significant primary care access constraints for adults or children.

2.9.11 Specialty Providers

2.9.11.1 The Contractor shall ensure access to specialty providers, as appropriate, for all enrollees. The Contractor shall ensure access standards and guidelines to specialty providers are met as specified in this Contract.

2.9.11.2 The Contractor's provider network shall include participating specialists with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (e.g. a pediatric cardiologist).

2.9.11.3 The Contractor shall ensure access to appropriate service settings for enrollees needing medically high-risk perinatal care, including both prenatal and neonatal care.

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

2.9.11.4.1 The Contractor has signed a contract with providers of the specialty types listed in the **MCO Manual** who accept new enrollees and are available on at least a referral basis; and

2.9.11.4.2 The Contractor is in compliance with access and availability requirements.

2.9.11.5 The Contractor shall ensure, at a minimum, the availability of the specialists listed in the **MCO Manual** with the ratio, distance, and appointment time requirements set in this Contract.

2.9.11.6 The Contractor will be required to provide a higher ratio of specialists per enrollee population and/or additional specialist types/enrollee ratios may be established, if it is determined by LDH that the Contractor does not meet the access standards specified in the Contract.

2.9.11.7 In accordance with 42 C.F.R. §438.208(c)(4), for enrollees with special health care needs determined to need a course of treatment or regular monitoring, the Contractor shall have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.

2.9.12 Hospitals

2.9.12.1 The Contractor shall ensure that hospital service providers are qualified to provide services under the Medicaid program.

2.9.12.2 The Contractor shall include, at a minimum, access to the following:

2.9.12.2.1 One (1) hospital that provides emergency room services, inpatient, and outpatient care in each parish in the state, provided the parish has such a hospital.

2.9.12.2.2 The Contractor must establish access to the following within their network of hospitals:

- Level III Obstetrical services;
- Level III Neonatal Intensive Care (NICU) services;
- Pediatric services;
- Trauma services;
- Burn services; and
- A Children's Hospital that meets the CMS definition in 42 C.F.R. §495.302 and §412.23(d).

2.9.13 Tertiary Care

Tertiary care is defined as health services provided by highly specialized providers, such as medical sub-specialists; these services frequently require complex technological and support facilities. The Contractor shall provide tertiary care services including trauma centers, burn centers, level III (high-risk) nurseries, rehabilitation facilities, and medical sub-specialists twenty-four (24) hours per day. If the Contractor does not have a full range of tertiary care services, the Contractor shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers.

2.9.14 Access to Medication Assisted Treatment

2.9.14.1 The Contractor shall ensure that substance use residential providers offer Medication Assisted Treatment (MAT) onsite or facilitate access to MAT offsite.

2.9.14.2 The Contractor shall report on enrollee access to MAT in a format and frequency specified in the **MCO Manual**.

2.9.14.3 The Contractor shall be responsible for conducting enrollee outreach and provider education and training regarding utilization of MAT to treat Opioid Use Disorder. This shall include, but not be limited to, assistance with federal requirements to become a DATA-waivered physician to expand access to MAT services.

2.9.14.4 LDH may pursue State Plan amendments or waivers to expand the substance use service array to include additional American Society of Addiction Medicine (ASAM) criteria and/or levels of care, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines.

2.9.15 Direct Access to Specialists for HIV Positive Enrollees

The Contractor shall provide direct access to an infectious disease health specialist(s) in-network for enrollees known to be HIV positive. This access shall be in addition to the enrollee's PCP if that provider is not an infectious disease specialist.

2.9.16 Direct Access to Women's Health Care

The Contractor shall provide direct access to a health specialist(s) in-network for MCO covered services necessary to provide women's routine and preventive health care services. This access shall be in addition to the enrollee's PCP if that provider is not a women's health specialist.

2.9.16.1 The Contractor shall demonstrate its network includes sufficient family planning providers to ensure timely access to covered services.

2.9.16.2 The Contractor shall notify and give each enrollee, including adolescents, the opportunity to use their own PCP or utilize any family planning service provider for family planning services without requiring a referral or authorization. Family planning services shall be available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments, and traditional contraceptive devices. The Contractor's family planning services shall also include preconception and interconception care services to optimize the enrollee's health entering pregnancy. The Contractor shall agree to make available all family planning services to enrollees as specified in this Contract.

2.9.16.3 Enrollees shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the Contractor's provider network without any restrictions as specified in 42 C.F.R. §431.51(b)(2). The out-of-network Medicaid enrolled family planning services provider shall bill the Contractor and be reimbursed no less than the Medicaid rate in effect on the date of service. Enrollees shall be encouraged by the Contractor to receive family planning services through the Contractor's network of providers to ensure continuity and coordination of the enrollee's total care. No additional reimbursements shall be made to the Contractor for enrollees who elect to receive family planning services outside the Contractor's provider network.

2.9.16.4 The Contractor may require family planning providers to submit claims or reports in specified formats before reimbursing services.

2.9.16.5 The Contractor shall maintain the confidentiality of family planning information and records for each individual enrollee including those of minor patients.

2.9.17 Prenatal Care Services

2.9.17.1 The Contractor shall assist all pregnant enrollees in choosing a pediatrician, or other appropriate PCP, for the care of their newborn babies before the beginning of the last trimester of gestation. The Contractor shall report on a quarterly basis the number and percentage of newborns for which a PCP has been selected prior to birth.

2.9.17.2 In the event that the pregnant enrollee does not select a pediatrician, or other appropriate PCP, the Contractor shall provide the enrollee with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one.

2.9.18 Other Service Providers

The Contractor shall ensure the availability of medical service providers including, but not limited to, ambulance services, durable medical equipment, orthotics, prosthetics and certain supplies, radiology, and laboratories.

2.9.19 Non-Emergency Medical Transportation

2.9.19.1 The Contractor shall have sufficient NEMT providers, including wheelchair lift equipped vans, to transport enrollees to medically necessary services when notified forty-eight (48) hours in advance, and the NEMT providers must be able to arrive and provide services within sufficient time to ensure the enrollee arrives at their appointment at least fifteen (15) minutes but no more than one (1) hour early.

2.9.19.2 For medically necessary non-emergent transportation requested by the enrollee or someone on behalf of the enrollee, the Contractor shall require its transportation providers to schedule the transportation so that the enrollee arrives at least fifteen (15) minutes but no more than one (1) hour before the appointment; does not have to wait more than one hour after the conclusion of the treatment for transportation home; and is not picked up prior to the completion of treatment.

2.9.19.3 If an enrollee requests a network provider who is located beyond the access standards provided in Attachment D, and the Contractor has an appropriate provider within the access standards who accepts new patients, it shall not be considered a violation of the access requirements for the Contractor to grant the enrollee's request. However, in such cases, the Contractor shall not be responsible for providing transportation for the enrollee to access care from this selected provider, and the Contractor shall notify the enrollee in writing as to whether or not the Contractor will provide transportation to seek care from the requested provider.

2.9.20 FQHC/RHC Clinic Services

2.9.20.1 The Contractor shall offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) in the State.

2.9.20.2 See the *Provider Reimbursement* section of this Contract for FQHC/RHC reimbursement requirements.

2.9.21 School-Based Health Clinics (SBHCs)

2.9.21.1 SBHC (certified by LDH OPH) services are those Medicaid services provided within school settings to Medicaid eligible children under the age of 21.

2.9.21.2 The Contractor shall offer a contract to each SBHC. The Contractor may stipulate that the SBHC follow all of the Contractor's required policies and procedures.

2.9.22 Laboratory

All laboratory testing sites providing services under this Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

2.9.23 Local Parish Health Clinics

2.9.23.1 The Contractor shall offer a contract to OPH for the provision of personal health services offered within the parish health units (e.g. immunizations, STI, family planning).

2.9.23.2 The Contractor shall coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for addressing public health issues shall be negotiated with LDH and reflect Louisiana public health priorities. The coordination of activities related to public health shall take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF (Medicaid), and the Contractor.

2.9.24 Specialized Behavioral Health Providers

2.9.24.1 The Contractor shall ensure behavioral health services are offered to address the needs of youth with serious emotional disorders, adults with Serious Mental Illness (SMI), enrollees with substance use disorders, enrollees with co-occurring mental health and substance use disorders and other developmental disorders. This shall include coordination with the Local Governing Entities (LGEs) for the provision of Medicaid services.

2.9.24.2 The Contractor shall ensure its provider network offers a range of basic and specialized behavioral health services as reflected in the **MCO Manual** and meets the network adequacy standards defined in this Contract. The provider network shall be adequate for the anticipated number of enrollees for the service area.

2.9.24.3 The Contractor shall develop its network to meet the needs of enrollees, including but not limited to, providing assessment to identify and treat the behavioral health needs of enrollees with past history or current display of aggression, runaway behavior, sexual offenses, or intellectual disability.

2.9.24.4 The Contractor shall develop, in coordination with LDH and other MCOs, a system to provide psychiatric prescribing support to primary care providers. Such support may be provided through consultation with psychiatrists regarding psychiatric prescribing practices.

2.9.24.5 The Contractor shall endorse real time consultation of primary care providers with behavioral health professionals or psychiatrists for behavioral health issues or consultations on medications.

2.9.24.6 The Contractor shall design its provider network to maximize the availability of community-based behavioral health care that reduces utilization of emergency services when lower cost community-based services are available and eliminates preventable hospital, nursing home, and other institutional admissions. The Contractor shall coordinate with other state agencies, as appropriate, to match services to meet behavioral health needs in the community with services and supports to meet the enrollee's other needs in the community, such as I/DD.

2.9.24.7 The Contractor shall design its provider network to increase the emerging use of peers as providers. This includes peers providing services for youth, adults and parents/families served in community and residential settings, and peer support specialists with OBH approved credentials to serve as qualified providers.

2.9.24.8 The Contractor shall ensure the provider network has a sufficient number of prescribers and other qualified behavioral health service providers to deliver services during evenings and weekends.

2.9.24.9 The Contractor shall have a fully operational network of behavioral health crisis response providers offering a complete array of crisis services, available twenty-four (24) hours per day, seven (7) days per week. Crisis services shall include an on-call, twenty-four (24)-hour crisis hotline, crisis counseling, crisis intervention and follow up, linkage to ongoing behavioral health management and intervention, and crisis stabilization for children. The Contractor shall maintain an active role in managing the process to ensure resolution of behavioral health crises in the community and referral to and assistance with placement in behavioral health services required by the individual in need.

2.9.24.10 The Contractor may also coordinate with community resources to expand the crisis response. The community-based crisis response system may include, but is not limited to, warm lines, mobile crisis teams, collaboration with law enforcement, crisis stabilization in alternative settings, and crisis stabilization/crisis receiving centers for adults. The Contractor shall familiarize itself with the local crisis collaborative and work with it to facilitate crisis resolution.

2.9.24.11 If shortages in provider network sufficiency are identified by LDH, the Contractor shall conduct outreach efforts approved by LDH, and take necessary actions to ensure enrollee access to medically necessary behavioral health services. The Contractor shall execute an ad hoc or single case agreement when a clinical need or a specialized behavioral health service is identified for an enrollee and a network provider is not available to meet that particular need. In such cases, all transportation necessary to receive medically necessary services shall be provided and reimbursed through the Contractor, including meals and lodging as appropriate.

2.9.24.12 The Contractor shall ensure that all placements are at the most appropriate, least restrictive, and medically necessary level to treat the specialty needs of the enrollee. The Contractor shall defer to state agencies regarding the appropriateness of residential placement options for Long Term Supports and Services outside of the scope of this Contract.

2.9.24.13 The Contractor shall require behavioral health providers to screen for basic medical issues.

2.9.24.14 The Contractor shall monitor and support development of local provider capacity for the purpose of identifying and filling gaps in service availability.

2.9.24.15 The Contractor shall report the number of out-of-state placements as specified by LDH. LDH may require the Contractor to take corrective action or employ other

remedies for non-compliance as authorized in the *Contract Non-Compliance* section in the event LDH determines the Contractor's rate of out-of-state placements to be excessive.

2.9.24.16 The Contractor shall develop policies and procedures to support the development of a workforce and provide services to the dually diagnosed, individuals with a co-occurring developmental disability and mental health diagnosis. These policies and procedures shall include:

2.9.24.16.1 A plan for how to improve and increase services available for individuals with behavioral health and developmental disabilities, including autism spectrum disorders, which incorporates reducing health disparities and long-range fiscal planning to support the training and fiscal sustainability of the provision of such services. This shall be submitted to LDH as part of readiness reviews for approval and annually thereafter.

2.9.24.16.2 An annual assessment of the number of providers serving enrollees with behavioral health and developmental disabilities and if the needs of this population are being met. This assessment shall include: the number of enrollees being served out of state due to a lack of appropriate services in state; whether these providers have waiting lists; and whether access to care standards are being met by these providers.

2.9.24.16.3 A database of trainers, consultants, and contractors that specialize in working with enrollees with dual diagnosis of behavioral health and developmental disabilities.

2.9.24.16.4 Training plans and curricula that address dual diagnosis. Training on dual diagnosis shall be offered to behavioral health network providers who are interested in certification and required for unlicensed staff working with this population. The training program and approach shall be reviewed and subject to approval by OBH and OCDD.

2.9.24.16.5 Incentives for providers to attain the certification.

2.9.24.17 The Contractor shall contract with at least one (1) psychiatric residential treatment facility (PRTF) within the State with the ability to work effectively with enrollees with dual diagnosis of developmental disabilities and behavioral health. The Contractor shall have at least one (1) Therapeutic Group Home (TGH) within the state with the ability to work effectively with enrollees with dual diagnosis of developmental disabilities and behavioral health.

2.9.24.18 The Contractor shall have community providers (i.e. psychiatrist, psychologist, social workers, advanced practice registered nurses (APRNs), mental health rehabilitation (MHR) providers, Wrap-around agencies (WAAs), etc.) within the State with the ability to effectively work with enrollees with dual diagnosis of developmental disabilities and behavioral health.

2.9.24.19 The Contractor shall make training available to licensed providers as needed to improve and increase access to behavioral health services for this population. The training program and approach must be reviewed and subject to approval by OBH and OCDD.

2.9.24.20 Unlicensed staff shall mandatorily complete training that addresses dual diagnosis and shall receive certification.

2.9.24.21 The Contractor shall offer provider trainings on integrated care including, but not limited to, appropriate utilization of basic behavioral health screens in the primary care setting and basic physical health screenings in the behavioral health setting.

2.9.25 Indian Health Care Providers (IHCPs)

2.9.25.1 The Contractor shall demonstrate that there are sufficient IHCPs participating in the provider network of the Contractor to ensure timely access to services available under the contract from such providers for Indian enrollees who are eligible to receive services.

2.9.25.2 The IHCPs, whether participating in the Contractor network or not, shall be paid for covered services provided to Indian enrollees who are eligible to receive services from such providers as follows:

2.9.25.2.1 At a rate negotiated between the Contractor and the IHCP; or

2.9.25.2.2 In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the Contractor would make for the services to a participating provider which is not an IHCP; and

2.9.25.2.3 Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 C.F.R. §447.45 and §447.46.

2.9.25.3 The Contractor shall permit any Indian who is enrolled with the Contractor and is eligible to receive services from an IHCP primary care provider participating as a network provider, to choose that IHCP as his or her PCP, as long as that provider has capacity to provide the services.

2.9.25.4 The Contractor shall permit Indian enrollees to obtain MCO covered services from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive such services.

2.9.25.5 Where timely access to covered services cannot be ensured due to few or no IHCPs, the Contractor shall be considered to have met the requirement in paragraph 42 C.F.R. §438.14(b)(1) if:

2.9.25.5.1 Indian enrollees are permitted by the Contractor to access out-of-state IHCPs; or

2.9.25.5.2 If this circumstance is deemed to be good cause for disenrollment from the State's managed care program in accordance with 42 C.F.R. §438.56(c).

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

2.9.26 Network Development and Management Plan

2.9.26.1 The Contractor shall develop and maintain a Network Development and Management Plan which ensures that MCO covered services are reasonably accessible to enrollees and are provided promptly in accordance with the urgency of the situation and the accessibility standards in this Contract.

2.9.26.2 The Contractor shall submit its Network Development and Management Plan in accordance with the **MCO Manual** annually, as amended, and as requested by LDH.

2.9.26.3 The Network Development and Management Plan shall include the Contractor's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access to all required services included in the Contract. When designing the network of providers, and entering into provider agreements, the Contractor shall consider the Medicaid enrollment; the expected utilization of services; the characteristics of specific populations included in this Contract; the number and types of providers required to furnish services; the number of contract providers who are not accepting new enrollees; the geographic location of providers and enrollees; distance, travel time, and the means of transportation ordinarily used by enrollees; and whether a provider location provides physical access for enrollees with disabilities.

2.9.27 Material Change to Provider Network

2.9.27.1 The Contractor shall provide advance written notice to LDH prior to any network provider agreement termination that materially impacts the Contractor's provider network, whether terminated by the Contractor 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 Contractor's ability to meet the performance and network standards as described in the Contract, including but not limited, to the following:

2.9.27.1.1 A termination or non-renewal of a hospital or residential treatment facility;

2.9.27.1.2 A termination or non-renewal of community health center or community mental health center;

2.9.27.1.3 A termination or non-renewal of a chain pharmacy within the Contractor's network;

2.9.27.1.4 A change to one (1) of the Contractor's material subcontractors, including its behavioral health subcontractor, if applicable;

2.9.27.1.5 Any change that would cause more than five percent (5%) of enrollees within the parish to change the location where services are received or rendered;

2.9.27.1.6 A decrease in the total of individual PCPs by more than five percent (5%);

2.9.27.1.7 A loss of any participating specialist which may impair or deny an enrollee's adequate access to providers;

2.9.27.1.8 A decrease in a behavioral health provider type by more than five percent (5%);

2.9.27.1.9 A loss of any participating behavioral health specialist which may impair or deny the enrollee's adequate access to providers; or

2.9.27.1.10 Other adverse changes to the composition of the Contractor's network which result in the Contractor's inability to meet the network adequacy and timely access to care standards of this Contract or which impair or deny an enrollee's adequate access to providers such as capping of patient loads by network providers impacting availability of qualified specialists in a region.

2.9.27.2 The Contractor shall provide or arrange for medically necessary covered services if the network becomes temporarily insufficient within a service area.

2.9.27.3 The Contractor shall submit required information on material changes to its provider network in accordance with the **MCO Manual** in the time period specified by LDH.

2.9.28 Provider Agreement Requirements

2.9.28.1 The Contractor shall enter into written agreements with providers to provide covered services.

2.9.28.2 In order to ensure that enrollees have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, the Contractor shall not have a contractual arrangement with any service provider in which the provider represents or agrees that it shall not contract with another MCO or in which the Contractor represents or agrees that it shall not contract with another provider. The Contractor shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.

2.9.28.3 The Contractor shall have written policies and procedures for selection and retention of providers in accordance with 42 C.F.R. §438.214.

2.9.28.4 The Contractor shall provide LDH with written provider credentialing and re-credentialing policies that are compliant with NCQA Health Plan Accreditation standards and all applicable state laws as part of readiness reviews and on an annual basis.

2.9.28.5 The Contractor's provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

2.9.28.6 The Contractor shall inform all providers, at the time they enter into a contract, about the enrollee's rights, and the availability of assistance, to file grievances and appeals, request State Fair Hearings, and request continuation of benefits that the Contractor seeks to reduce or terminate during an appeal or State Fair Hearing, if filed within the allowable timeframes, although the enrollee may be liable for the cost of any continued benefits while the appeal or State Fair Hearing is pending if the final decision is adverse to the enrollee.

2.9.28.7 The Contractor shall require that providers not bill enrollees for covered services in any amount greater than would be owed if the Contractor provided the services directly.

2.9.28.8 The Contractor shall require that providers offer the same services to enrollees as those offered to individuals not receiving Medicaid, provided that they are MCO covered services. Providers shall also be required to treat Medicaid enrollees equally in terms of scope, quality, duration, and method of delivery of services, unless specifically limited by regulation. Providers are not required to accept every enrollee requesting service.

2.9.28.9 The Contractor shall require the provider to report to the Contractor loss of accreditation, suspension, or action taken that could result in loss of accreditation, inclusive of all documentation from the accrediting body, within twenty (24) hours of receipt of notification, if required to be accredited.

2.9.28.10 The Contractor shall require the provider to report immediately cancellation of any required insurance coverage, licensure, or certification to the MCO.

2.9.28.11 As required by 42 C.F.R. §438.3(k) and §438.230, the Contractor shall be responsible for overseeing all providers' performance and shall be held accountable for any function and responsibility that it delegates to any provider, including, but not limited to:

2.9.28.11.1 All provider agreements must fulfill the requirements of 42 C.F.R. Part 438 that are appropriate to the service or activity delegated under the agreement;

2.9.28.11.2 Prior to executing a network provider agreement, the Contractor shall evaluate the prospective provider's and/or subcontractor's qualifications and ability to perform the activities to be delegated; and

2.9.28.11.3 The Contractor shall develop a template for provider agreements that shall be approved by LDH that specifies the requirements and reporting responsibilities delegated to the provider and provides for revoking delegation or imposing other non-compliance actions and penalties if the provider's performance is inadequate.

2.9.28.12 Notification of amendments or changes to any provider agreement which, in accordance with this section, materially affects this Contract, shall be provided to LDH prior to the execution of the amendment in accordance with the *Amendments* section of this Contract.

2.9.29 Credentialing and Re-credentialing of Providers and Clinical Staff

2.9.29.1 The Contractor shall have a written credentialing and re-credentialing process that complies with 42 C.F.R. §438.12, §438.206, §438.214, §438.224, §438.230, §438.602(b) and NCQA Health Plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the Contractor selects and directs its enrollees to see a specific provider or group of providers. These procedures shall be submitted to LDH during readiness review, and subsequently any time a change is made, and annually thereafter by contract year.

2.9.29.2 Prior to entering into a provider agreement, the Contractor shall ensure that providers have been properly credentialed and screened by the State in a process compliant with §438.602(b) to ensure provider facilities, organizations, and staff meet all qualifications and requirements for participation in the Medicaid program.

2.9.29.3 The Contractor shall accept the credentialing decisions of the Credentials Verification Organization (CVO) Credentialing Committee. Within thirty (30) calendar days of receipt of an approved credentialing decision, the Contractor shall load providers in its claims processing system.

2.9.29.4 The Contractor shall provide information to the State's provider management contractor on contracted providers in accordance with the **MCO Manual**.

2.9.29.5 The Contractor 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 with the Contract. The policies and procedures shall include, but are not limited to, the encouragement of applicable board certification.

2.9.29.6 The Contractor shall develop and implement a mechanism, subject to LDH approval, for reporting quality deficiencies, which result in suspension or termination of a network provider/subcontractor(s). This process shall be submitted as part of readiness reviews and annually thereafter, and prior to implementation of revisions.

2.9.30 Credentialing Committee

The Contractor shall participate on the CVO's Credentialing Committee to evaluate provider credentialing files (including re-credentialing files) using a peer review process. The credentialing committee is responsible for credentialing decisions which shall be accepted by the Contractor.

2.9.31 Network Guidelines for Providers Needing DCFS Licensing

It is the Contractor's responsibility to ensure its providers comply with DCFS licensing requirements as applicable and can submit proof of compliance upon request. The Contractor shall follow communication protocols as established by DCFS if necessary.

2.9.32 Provider-Enrollee Communication Anti-Gag Clause

2.9.32.1 Subject to the limitations described in 42 C.F.R. §438.102(a)(2), the Contractor shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a enrollee, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the Contract, for the following:

2.9.32.1.1 The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

2.9.32.1.2 Any information the enrollee needs in order to decide among relevant treatment options;

2.9.32.1.3 The risks, benefits and consequences of treatment or non-treatment; and

2.9.32.1.4 The enrollee's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.

2.9.32.2 Any Contractor that violates the anti-gag provisions set forth in 42 C.F.R. §438.102(a)(1) shall be subject to intermediate sanctions.

2.9.32.3 The Contractor shall comply with the provisions of 42 C.F.R. §438.102(a)(1)(ii) concerning the integrity of professional advice to enrollees, including interference with provider's advice to enrollees and information disclosure requirements related to physician incentive plans.

2.9.33 Pharmacy Network, Access Standards, and Reimbursement

2.9.33.1 The Contractor shall provide a pharmacy network that complies with the requirements of this Contract and the **MCO Manual**. At a minimum, the Contractor's pharmacy network shall include only licensed and registered pharmacies who are appropriately screened by and enrolled with the State and that conform to the Louisiana Board of Pharmacy rules concerning the records to be maintained by a pharmacy.

2.9.33.2 The Contractor shall not prohibit any pharmacy or pharmacist participating in the Medicaid program from contracting as a network provider provided the pharmacy or pharmacist is licensed and in good standing with the Louisiana State Board of Pharmacy and accepts the terms and conditions of the contract offered to them by the Contractor.

2.9.33.3 Out-of-State Pharmacy Providers

2.9.33.3.1 Out-of-state pharmacies shall only be allowed in the Contractor's network to secure reimbursement for a specific claim only under the following circumstances:

2.9.33.3.1.1 When an emergency arises from an accident or illness; or

2.9.33.3.1.2 When the health of the individual would be endangered if he/she undertook travel or if care and services are postponed until his/her return to Louisiana; or

2.9.33.3.1.3 When it is general practice for residents of a particular locality to use medical resources outside of the state; or

2.9.33.3.1.4 When the medical care and services, or needed supplementary resources, are not available within the state. Prior authorization for these services is required.

2.9.33.3.2 If services are provided to a Medicaid enrollee in accordance with the criteria detailed above, the Contractor shall allow the provider to secure payment of the claim, but only to finalize the claim at issue, not to allow continuous and active network provider status. The Contractor may include out-of-state pharmacies that supply services not available within the state as a network provider.

2.9.33.4 The Contractor shall have a network pharmacy audit program that includes, at a minimum:

2.9.33.4.1 Random audits to determine provider compliance with the policies, procedures and limitations outlined in the provider agreement and this Contract. The Contractor shall not utilize contingency fee based pharmacy audits.

2.9.33.4.2 The Contractor shall submit to LDH the policies of its audit program for approval prior to initiating audits.

2.9.33.5 The Contractor shall ensure that pharmacies submit the NPI of the prescriber on all pharmacy claims. The Contractor shall deny claims submitted without the NPI of the prescriber.

2.9.33.6 The Contractor shall educate network providers how to access the PDL on their websites. The Contractor shall also provide provider education on pharmacy claims processing and payment policies and procedures.

2.9.33.7 In accordance with Louisiana law, the Contractor may negotiate the ingredient cost reimbursement in its contracts with providers. However, the Contractor shall:

2.9.33.7.1 Reimburse no less than the FFS rate on the date of service as required by La. R.S. 46:460.36(D);

2.9.33.7.2 Add any state imposed provider fees for pharmacy services, on top of the cost of the prescription (ingredient cost + professional dispensing fee or usual and customary (U&C), whichever is lower);

2.9.33.7.3 Update the ingredient costs of medications at least weekly and within twenty-four (24) hours of new rates being posted;

2.9.33.7.4 Base Maximum Allowable Cost (MAC) price lists on generic drugs with a FDA rating beginning with an "A";

2.9.33.7.5 Make the drug pricing list available to pharmacies for review, upon request; and

2.9.33.7.6 Afford individual pharmacies a chance to appeal inadequate reimbursement.

2.9.33.8 The Contractor and the Contractor's PBM shall not charge pharmacy providers claims processing or provider enrollment fees. This Section does not prohibit sanctioning pharmacy providers.

2.9.33.9 Pharmacy Claims Dispute Management

The Contractor shall maintain an internal claims dispute process to permit pharmacies to dispute the reimbursement paid for any claim made for the dispensing of a drug as specified in the **MCO Manual**.

2.9.33.10 Mail Order/Mail Service Pharmacy

The Contractor shall not require its members to use a mail service pharmacy. Mail order shall not exceed more than one percent (1%) of all pharmacy claims. Enrollees shall not be charged anything above applicable copays (e.g. shipping and handling fees).

2.9.33.11 Specialty Drugs and Specialty Pharmacies

2.9.33.11.1 LDH recognizes the importance of providing adequate access to specialty drugs to Medicaid enrollees while ensuring proper management of handling and utilization. The Contractor shall comply with the specialty drug and specialty pharmacy requirements specified in the **MCO Manual** and this Contract.

2.9.33.11.2 A specialty drug is defined as a prescription drug which meets all of the following criteria:

2.9.33.11.2.1 The drug is not routinely dispensed at a majority of retail community pharmacies due to physical or administrative requirements that limit preparation and/or delivery in the retail community pharmacy

environment. Such drugs may include, but are not limited to, chemotherapy, radiation drugs, intravenous therapy drugs, biologic prescription drugs approved for use by the federal Food and Drug Administration, and/or drugs that require physical facilities not typically found in a retail community pharmacy, such as a ventilation hood for preparation;

2.9.33.11.2.2 The drug is used to treat complex, chronic, or rare medical conditions:

- That can be progressive; or
- That can be debilitating or fatal if left untreated or undertreated; or
- For which there is no known cure.

2.9.33.11.2.3 The drug requires special handling, storage, and/or has distribution and/or inventory limitations;

2.9.33.11.2.4 The drug has a complex dosing regimen or requires specialized administration;

2.9.33.11.2.5 Any drug that is considered to have limited distribution by the federal Food and Drug Administration;

2.9.33.11.2.6 The drug requires:

- Complex and extended patient education or counseling; or
- Intensive monitoring; or
- Clinical oversight; and

2.9.33.11.2.7 The drug has significant side effects and/or risk profile.

2.10 Provider Services and Support

2.10.1 Provider Advisory Council

2.10.1.1 The Contractor shall establish a Provider Advisory Council to provide input and advice to enhance the Contractor's service delivery, improve provider satisfaction and enrollee experience, promote data sharing and value-based payment strategies, and enable regular provider participation in clinical policy development and provider operations.

2.10.2 Provider Directory

2.10.2.1 The Contractor shall maintain a complete and accurate provider directory of PCPs, behavioral health providers, hospitals, specialists, sub-specialists, pharmacies, and

ancillary service providers, that is made available in prevalent languages and alternative formats, upon request, and in compliance with 42 C.F.R. 438.10(h)(1) and (2) and the **MCO Manual**.

2.10.2.2 The Contractor shall provide all PCPs with a current hard copy listing of referral providers, including behavioral health providers on a quarterly basis. The Contractor shall also maintain an updated electronic, web-accessible version of the referral provider listing.

2.10.2.3 The Contractor shall also include in the provider directory the following information:

2.10.2.3.1 Instructions for the enrollee to contact the Contractor's toll-free enrollee services telephone line for assistance in finding a provider or a convenient pharmacy.

2.10.2.3.2 Note of prior authorization or referral requirement for providers, if applicable.

2.10.2.4 The Contractor shall provide the provider directory in a manner agreeable to the enrollee either by mail or by utilizing the Contractor's website. The Contractor shall distribute information regarding provider directories to new enrollees within thirty (30) calendar days of receipt of notification of enrollment in the Contractor's MCO. Such information shall include how to access the provider directory, including the right to request a hard copy and to contact the Contractor's member services line to inquire regarding a provider's participation in the network. Enrollees receiving a hard copy of the provider directory shall be advised that the network may have changed since the directory was printed, and how to access current information regarding the participating providers.

2.10.2.5 An electronic directory shall be made available on the Contractor's website in a machine readable and searchable file. The electronic directory shall be made easily accessible to enrollees. This means the directory shall have a clearly identifiable link or tab and shall not require an enrollee account or policy number to access the directory. The provider directory must accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

2.10.2.6 The Contractor shall include, in both electronic and paper directories, a customer service email address, telephone number and/or electronic link that individuals may use to notify the Contractor of inaccurate provider directory information.

2.10.2.7 The Contractor shall review and update paper provider directories at least monthly and electronic provider directories no later than thirty (30) calendar days after the Contractor receives updated provider information.

2.10.2.8 The Contractor shall audit provider directory information for accuracy in accordance with this Contract and the **MCO Manual** for all PCPs, OB/GYNs, hospitals, and behavioral health providers at least quarterly, and audit at least a statistically valid sample size of its provider directory information on a more frequent, periodic basis.

Documentation of such audits shall be retained and made available to LDH upon request.

LDH reserves the right to conduct periodic audits to verify the accuracy of the Contractor's provider directory data. LDH will utilize full discretion in determining the audit type, criteria, and methodology. LDH may penalize the Contractor for inaccurate provider directories using one (1) or more remedies in the *Contract Non-Compliance* section and Attachment E, *Table of Monetary Penalties*.

2.10.3 Provider Relations

The Contractor shall:

2.10.3.1 The Contractor shall maintain an updated electronic, web-accessible listing of referral providers, including behavioral health providers;

2.10.3.2 Establish and maintain a formal provider relations function to respond timely and adequately to inquiries, questions, and concerns from network providers;

2.10.3.3 Provide sufficient information and procedural guidelines to all providers in order to operate in full compliance with this Contract and all applicable federal and State laws and regulations;

2.10.3.4 Provide sufficient information and procedural guidelines to all providers that address services excluded or limited by Louisiana Medicaid;

2.10.3.5 Maintain a protocol that facilitates communication to and from providers and the Contractor, and which shall include, but not be limited to, a provider newsletter, electronic mail, periodic provider meetings, and updated contact information for Provider Relations representatives that includes their areas of responsibility;

2.10.3.6 Except as otherwise required or authorized by LDH or by operation of law, ensure that providers receive thirty (30) calendar days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect;

2.10.3.7 Work in collaboration with providers to actively improve the quality of care provided to enrollees, consistent with the quality improvement goals and quality measures, and all other requirements of this Contract;

2.10.3.8 Have trained provider relations staff dedicated to this Contract and available to providers to address provider issues Monday through Friday from 7 a.m. to 7 p.m. Central Time and to handle non-routine prior authorization requests twenty-four (24) hours per day seven (7) days per week;

2.10.3.9 Have a process in place to handle after-hours inquiries from providers seeking to verify enrollment for an enrollee in need of urgent or emergency services. The

Contractor and its providers shall not require such verification prior to providing emergency services;

2.10.3.10 Provide for arrangements to handle emergent provider issues twenty-four (24) hours per day seven (7) days per week;

2.10.3.11 Provide ongoing provider training, respond to provider inquiries and provide general assistance to providers regarding program operations and requirements; and

2.10.3.12 Ensure regularly scheduled visits to provider sites, as well as ad hoc visits as circumstances dictate and provide technical assistance, including assistance on MCO systems and billing practices. Documentation of these visits shall be provided upon request by LDH and shall include sign-in sheets, agendas, documented follow-up action items (as appropriate), and any distributed materials.

2.10.4 Provider Toll-Free Telephone Line

2.10.4.1 The Contractor shall operate a provider toll-free telephone line to respond to provider questions, comments and inquiries. The telephone line shall include the ability for providers to access interpreter services as described in the *Enrollee Services* section. The telephone line shall have the capability to track provider call management metrics and comply with the member call center performance standards outlined in the *Enrollee Services* section.

2.10.4.2 The Contractor shall develop telephone line procedures that address the hiring and training of personnel, staffing ratios, hours of operation, response standards, monitoring of calls via recording or other means, and compliance with this Contract's standards.

2.10.4.3 After normal business hours, the provider service component of the telephone line shall include the capability of providing information regarding normal business hours and instructions for verifying enrollment for any enrollee with an emergency or urgent medical condition.

2.10.5 Provider Website

2.10.5.1 The Contractor shall have a provider website. The provider website may be developed on a page within the Contractor's existing website (such as a portal) to meet these requirements. Requirements for the website are contained in the **MCO Manual**.

2.10.5.2 The Contractor shall maintain forms on its provider website to allow submittal of complaints and disputes electronically. In addition, the Contractor shall provide providers with an address to submit grievances and appeals in writing and a phone number to submit grievances and appeals by telephone.

2.10.5.3 The Contractor's provider website shall provide a secure provider portal with the following capabilities:

2.10.5.3.1 The Contractor shall use current state and federal standards and procedures (e.g., HL7, HIPAA, CMS, CPT, ICD-10, and DSM-5) for all provider used systems and maintain a uniform service and provider taxonomy for billing and information management purposes.

2.10.5.3.2 The Contractor shall, with appropriate enrollee consent, allow the provider access to enrollee clinical data including assessments and plans of care and/or relevant data necessary to provide for appropriate coordination of care.

2.10.5.3.3 The Contractor shall provide online accessible methodology for providers to review and update staff rosters of credentialed and contracted providers of mental health rehabilitation services.

2.10.5.3.4 The Contractor shall grant user-defined LDH access to and training on the provider website.

2.10.5.3.5 The Contractor shall provide a link to the Medicaid Behavioral Health Services Provider Manual and the Contractor's provider handbook.

2.10.5.4 The Contractor shall provide, in accordance with national standards, claims inquiry information to providers and subcontractors via the Contractor's website.

2.10.5.5 The Contractor shall develop and maintain methods to communicate policies, procedures and relevant information to providers through its website.

2.10.5.6 The Contractor shall provide all qualified behavioral health service providers and subcontractors access to the Medicaid Behavioral Health Services Provider Manual, and any updates, either through the Contractor's website, or by providing paper copies to providers upon request.

2.10.5.7 The Contractor shall remain compliant with HIPAA privacy and security requirements when providing any enrollee eligibility or member identification information on the website.

2.10.5.8 The Contractor website shall be in compliance with Section 508 of the Americans with Disabilities Act (ADA), and meet all standards the ADA sets for people with visual impairments and disabilities that make usability a concern.

2.10.5.9 The Contractor is responsible for ensuring that the website is maintained with accurate and current information and is compliant with requirements of this Contract.

2.10.5.10 In addition to the specific website requirements outlined above, the Contractor's website shall be functionally equivalent to the website maintained by the LDH FI.

2.10.6 Provider Handbook

2.10.6.1 The Contractor shall maintain and distribute a provider handbook which includes specific information about MCO covered services, non-MCO covered services, and

other requirements of the Contract relevant to Provider responsibilities. The Contractor shall submit an updated provider handbook to LDH annually and as requested by LDH. Requirements for the handbook are located in the **MCO Manual**.

2.10.6.2 The Contractor shall develop and issue a provider handbook to all providers at the time provider agreements are executed and annually as the provider handbook is updated.

2.10.6.3 The Contractor may choose not to distribute a hard copy of the provider handbook, provided it submits a written notification to all providers that explains how to obtain the provider handbook from the Contractor's website. This notification shall also detail how the provider can request a hard copy from the Contractor at no charge to the provider. All provider handbooks and bulletins shall be in compliance with state and federal laws. The provider handbook shall serve as a source of information regarding MCO covered services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all Contract requirements are met.

2.10.6.4 The Contractor shall disseminate bulletins as needed to incorporate any changes to the provider handbook.

2.10.6.5 The Contractor shall submit to LDH for approval as part of readiness reviews a provider handbook specific to the Louisiana Medicaid managed care program.

2.10.7 Provider Education and Training

2.10.7.1 The Contractor shall provide training to all providers and their staff regarding the requirements of the Contract, including limitations on provider marketing, and identification of special needs of enrollees. The Contractor shall conduct initial training within thirty (30) calendar days of placing a newly contracted provider, or provider group, on active status. The Contractor shall also conduct ongoing training, as deemed necessary by the Contractor or LDH, in order to ensure compliance with program standards and the Contract.

2.10.7.2 The Contractor shall submit a copy of the Provider Training Manual and training schedule to LDH for approval as part of readiness reviews. Any changes to the manual shall be submitted to LDH at least thirty (30) calendar days prior to the scheduled change and dissemination of such change.

2.10.7.3 The Contractor shall develop and offer specialized initial and ongoing training in the areas including, but not limited to, billing procedures and service authorization requirements.

2.10.7.4 The Contractor shall provide prescriber education, training and outreach to support the implementation, maintenance, and updating of its behavioral health pharmacy management activities, including, but not limited to, education and training relative to the Preferred Drug List, prior authorization requirements, fail first, step-therapy, approved prescribing caps, and relevant enrollee appeal, expedited appeal, and peer-to-peer procedures and protocols. The Contractor shall submit its tentative prescriber

training and education schedule or plan to LDH as part of readiness reviews for approval.

2.10.7.5 The Contractor shall provide technical assistance and network development training (e.g., billing, behavioral health services and authorization, linguistic/cultural competency, etc.) for its behavioral health providers, including required trainings for certain behavioral health providers (e.g. Child and Adolescent Needs and Strengths (CANS), Level of Care Utilization System (LOCUS), OBH standardized training for non-licensed providers, etc.). The Contractor shall maintain records of such training including completion dates, which shall be made available to LDH upon request.

2.10.7.6 The Contractor shall ensure that behavioral health providers (i.e. organizations, practitioners and staff) are trained and/or meet training requirements in accordance with State laws and rules and the **MCO Manual** for the MCO covered services.

2.10.7.7 The Contractor shall provide at least seven (7) calendar days advance notice of all trainings to LDH, and LDH shall be invited to attend all provider sessions. The Contractor shall maintain and provide upon LDH request all provider training reports identifying training topics provided, dates, sign-in sheets, invited/attendees' lists, and organizations trained.

2.10.8 Provider Satisfaction Surveys

2.10.8.1 To assess overall satisfaction, the Contractor shall conduct an annual provider survey, or actively participate in and support a statewide provider survey if directed to do so by LDH.

2.10.8.2 If directed by LDH to participate in a statewide survey, LDH or its External Quality Review Organization (EQRO) will provide further instructions.

2.10.8.3 If LDH does not conduct a statewide survey, the Contractor shall comply with provider satisfaction survey requirements in the **MCO Manual**.

2.10.9 Provider Complaint System

2.10.9.1 Definition of Provider Complaint

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 Contractor, voicing dissatisfaction with a policy, procedure, payment or any other communication or adverse action by the Contractor, excluding request of reconsideration or appeal for specific individual claims. It does include general complaints about claim payment policies. Grievances and appeals filed by providers on behalf of an enrollee should be documented and processed in accordance with enrollee grievance and appeals policies.

The Contractor shall establish a Provider Complaint System to track the receipt and resolution of provider complaints from in-network and out-of-network providers.

2.10.9.2 Definition of Adverse Action

For the purposes of this subsection, an adverse action is defined as:

- 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 failure to provide services in a timely manner, as defined in this section; or
- The failure of the MCO to act within the timeframes provided in this Contract.

2.10.9.3 This system must be capable of identifying and tracking provider complaints received by phone, in writing, or in person.

2.10.9.4 As part of the Provider Complaint system, the Contractor shall:

2.10.9.4.1 Have dedicated provider relations staff for providers to ask questions, file a provider complaint and resolve problems;

2.10.9.4.2 Identify a key staff person specifically designated to receive and process provider complaints;

2.10.9.4.3 Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider agreement provisions, collecting all pertinent facts from all parties and applying the Contractor's written policies and procedures; and

2.10.9.4.4 Ensure that MCO executives with the authority to require corrective action are involved in the provider complaint escalation process. The Contractor shall provide the names, phone numbers and e-mail addresses of these executives to LDH within one (1) week of contract approval, and within two (2) business days of any changes.

2.10.9.5 The Contractor shall have and implement written policies and procedures which detail the operation of the Provider Complaint System. The Contractor shall submit its Provider Complaint System policies and procedures to LDH for approval as part of readiness reviews.

2.10.9.6 The Contractor shall acknowledge provider complaints within business three (3) days and shall resolve complaints as soon as feasible, not to exceed thirty (30) calendar days unless both the provider and LDH have been notified of the outstanding issues, including a timeline for resolution and reason for the extension of time.

2.10.9.7 The policies and procedures shall include, at a minimum:

2.10.9.7.1 Allow providers to file a written complaint and a description of how providers file complaints with the Contractor and the resolution time;

2.10.9.7.2 A description of how and under what circumstances providers are advised that they may file a complaint with the Contractor;

2.10.9.7.3 A description of how provider relations staff are trained to distinguish between a provider complaint and an enrollee grievance or appeal in which the provider is acting on the enrollee's behalf;

2.10.9.7.4 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;

2.10.9.7.5 A process for thoroughly investigating each complaint and for collecting pertinent facts from all parties during the investigation;

2.10.9.7.6 A description of the methods used to ensure that MCO executive staff with the authority to require corrective action are involved in the complaint process, as necessary;

2.10.9.7.7 A process for giving providers or their representatives the opportunity to present their cases in person;

2.10.9.7.8 Identification of specific individuals who have authority to administer the provider complaint process;

2.10.9.7.9 A system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation, whether received by telephone, in person, or in writing; and

2.10.9.7.10 A provision requiring the Contractor to report the status of all provider complaints and their resolution to LDH on a monthly basis in the format required by LDH.

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

2.10.9.9 The Contractor shall not prohibit, discourage, intimidate, or in any other way take retaliatory action against a provider that reports any complaint to LDH.

2.11 Provider Reimbursement

The Contractor shall administer an effective, accurate and efficient claims processing system that adjudicates provider claims for covered services that are filed within the timeframes specified in this Contract and in compliance with all applicable State and Federal laws, rules and regulations.

2.11.1 Minimum Reimbursement to In-Network Providers

2.11.1.1 The Contractor shall provide reimbursement for covered services provided by an in-network provider.

2.11.1.2 For MCO covered services, the Contractor's rate of reimbursement shall be no less than the published Medicaid FFS rate in effect on the date of service or that is contained on the weekly procedure file sent to the Contractor by the FI, or its equivalent, unless mutually agreed to by both the Contractor and the provider in the provider agreement.

2.11.1.3 For inpatient hospital services, the Contractor shall have a system with the capacity to group claims and reimburse under a Diagnosis Related Groups (DRG) methodology as defined by LDH within one hundred eighty (180) days of notification by LDH that such reimbursement method is required. Upon implementation, the Contractor's rate of reimbursement shall be no less than the DRG rate established by LDH, unless mutually agreed to by both the Contractor and the provider in the provider agreement.

2.11.1.4 For cost-based services, the Contractor's rate of reimbursement shall be no less than the published Medicaid FFS rate adjusted by the cost-based settlement.

2.11.1.5 For cases eligible for outlier payments, the Contractor's rate of reimbursement shall be no less than the published Medicaid FFS rate plus the additional calculated outlier amount.

2.11.1.6 For providers with state enrollment effective dates equal to or less than ninety (90) calendar days prior to execution of the Contractor's provider agreement, such reimbursement shall be provided for dates of services on or after the state enrollment effective date. For providers with state enrollment effective dates greater than ninety (90) calendar days prior to execution of the Contractor's provider agreement, such reimbursement shall be provided for dates of services on or after the provider agreement execution date. In either case, if a provider would otherwise be eligible for reimbursement at an earlier date under La. R.S. 46:460.42, then reimbursement shall be provided for dates of service on or after that date.

2.11.2 FQHC/RHC Contracting and Reimbursement

2.11.2.1 The Contractor shall ensure that its payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for services to enrollees are greater than or equal to the payment amounts described in 42 U.S.C. §1396a(bb). In order to comply with this requirement, the Contractor shall pay FQHCs and RHCs at least the amount

LDH would pay for such services on a fee-for-service basis as defined by the Prospective Payment System (PPS) rate in effect on the date of service for each encounter or an approved alternative payment methodology.

2.11.2.2 If the Contractor is unable to contract with an FQHC or RHC, the Contractor is not required to reimburse that FQHC or RHC without prior authorization for out-of-network services unless:

2.11.2.2.1 The medically necessary services are required to treat an emergency medical condition; or

2.11.2.2.2 FQHC/RHC services are not available through at least one (1) MCO within LDH's established distance travel standards.

2.11.2.2.3 The Contractor may stipulate that reimbursement will be contingent upon receiving a clean claim and all the medical information required to update the enrollee's medical record.

2.11.3 Indian Health Service (IHS) Providers

The Contractor shall reimburse the IHS provider at the annual rates published by the IHS in the Federal Register. IHS issues the payment rate based on a calendar year that will be effective retroactive to January 1 of that year. The Contractor shall recycle claims for the calendar year to capture the adjusted rate. See 42 C.F.R. §438.14(c).

2.11.4 Reimbursement to Out-of-Network Providers

2.11.4.1 The Contractor shall make payment for covered emergency and post-stabilization services that are furnished to enrollees by providers that have no arrangements with the Contractor for the provision of such services. The Contractor shall reimburse the provider one hundred percent (100%) of the Medicaid rate for emergency services. In compliance with Section 6085 of the Deficit Reduction Act (DRA) of 2005, reimbursement by the Contractor to out-of-network providers for the provision of emergency services shall be no more than the Medicaid rate.

2.11.4.2 For services that do not meet the definition of emergency services, the Contractor shall compensate, at a minimum, ninety percent (90%) of the published Medicaid rate in effect on the date of service to out-of-network providers to whom they have made at least three (3) documented attempts to include in their network (except as noted in this section for FQHCs, RHCs and IHS providers). The Contractor may require prior authorization for out-of-network services, unless services are required to treat an emergency medical condition.

2.11.4.3 The Contractor shall not make payment for Community Psychiatric Support Treatment (CPST) or Psychosocial Rehabilitation (PSR) services that are furnished to enrollees by providers that are out-of-network. The Contractor may make payment for CPST or PSR services only to those providers who are credentialed and participating in the provider network of the Contractor for the provision of such

services, or who are licensed and accredited and have a single case agreement with the Contractor for provision of such services.

2.11.5 Effective Date of Payment for New Enrollees

The Contractor is responsible for payment of MCO covered services from the effective date of an enrollee's eligibility for Louisiana Medicaid. This includes reimbursement to an enrollee for payments already made by the enrollee for Medicaid payable services during the retroactive eligibility period. The date of enrollment in an MCO will match the Medicaid eligibility effective date and may be retroactive for a period not to exceed twelve (12) months.

2.11.6 Claims Processing Requirements

2.11.6.1 At a minimum, the Contractor shall run one (1) provider payment cycle per week, on the same day each week, as determined by the Contractor.

2.11.6.2 The Contractor shall support a CAQH/CORE compliant interface to the automated clearinghouse (ACH) that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

2.11.6.3 The Contractor shall encourage that its providers submit and receive claims information through electronic data interchange (EDI) as an alternative to the filing of paper-based claims.

2.11.6.4 Claims shall be processed in adherence to information exchange and data management requirements specified in this Contract.

2.11.6.5 The Contractor shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid, or CHIP programs for fraud, abuse, or waste or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employs someone on this list. The Contractor shall not pay any claim submitted by a provider that is on payment suspension and/or withhold under the authority of LDH or its authorized agent(s).

2.11.6.6 The Contractor shall inform all network providers about Clean Claim requirements. The Contractor shall make requirements and guidelines for claims coding and processing that are specific to Provider types available to network providers. The Contractor shall notify providers ninety (90) calendar days before implementing changes to claims coding and processing guidelines, or as soon as possible if directed by LDH pursuant to state or federal law to implement such change earlier.

2.11.7 Inappropriate Payment Denials

If the Contractor has a pattern of inappropriately denying, delaying or recouping provider payments for services, the Contractor may be subject to suspension of new enrollments, non-compliance actions, 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 (i.e. LDH is knowledgeable about the documented abuse from other sources).

2.11.8 Payment for Emergency Services and Post-Stabilization Services

2.11.8.1 The Contractor shall reimburse providers for emergency services rendered without a requirement for service authorization of any kind.

2.11.8.2 The Contractor's protocol for provision of emergency services shall specify that emergency services shall be covered when furnished by a provider with whom the Contractor does not have a subcontract or referral arrangement.

2.11.8.3 The Contractor may not limit what constitutes an emergency medical condition on the basis of diagnoses or symptoms.

2.11.8.4 The Contractor shall not deny payment for treatment obtained under either of the following circumstances:

2.11.8.4.1 An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

2.11.8.4.2 A representative of the Contractor instructs the enrollee to seek emergency services.

2.11.8.5 The Contractor shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent's failure to notify the enrollee's primary care provider or the Contractor of the enrollee's screening and treatment within ten (10) calendar days of presentation for emergency services.

2.11.8.6 The Contractor shall be financially responsible for emergency medical services, including transportation, and shall not retroactively deny a claim for emergency services, including transportation, to an emergency provider because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, was subsequently determined to be non-emergency in nature.

2.11.8.7 The Contractor is financially responsible for post-stabilization care services, as specified in 42 C.F.R. §438.114(e) and §422.113(c), obtained within or outside the network that are:

2.11.8.7.1 Pre-approved by a network provider or other Contractor representative; or

2.11.8.7.2 Not pre-approved by a network provider or other Contractor representative, but:

2.11.8.7.2.1 Administered to maintain the enrollee's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further post-stabilization care services;

2.11.8.7.2.2 Administered to maintain, improve or resolve the enrollee's stabilized condition if the Contractor:

- Does not respond to a request for pre-approval within one (1) hour;
- Cannot be contacted; or
- Contractor's representative and the treating physician cannot reach an agreement concerning the enrollee's care and a network physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of 42 C.F.R. §422.113(c)(3) is met.

2.11.8.7.2.3 Are for post-stabilization hospital-to-hospital ambulance transportation of enrollees with a behavioral health condition, including hospital to behavioral health specialty hospital.

2.11.8.8 The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor as responsible for coverage and payment as per 42 C.F.R. §438.114(d). The Contractor's financial responsibility ends for post stabilization care services it has not pre-approved when:

2.11.8.8.1 A network physician with privileges at the treating hospital assumes responsibility for the enrollee's care;

2.11.8.8.2 A network physician assumes responsibility for the enrollee's care through transfer;

2.11.8.8.3 A representative of the Contractor and the treating physician reach an agreement concerning the enrollee's care; or

2.11.8.8.4 The enrollee is discharged.

2.11.9 Non-Payment for Specified Services

The Contractor shall deny payment to providers for deliveries occurring before thirty-nine (39) weeks without a medical indication.

2.11.10 Provider Preventable Conditions

2.11.10.1 The Contractor shall deny payment to providers for Provider Preventable Conditions that meet the following criteria:

2.11.10.1.1 Is identified in the State Plan;

2.11.10.1.2 Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

2.11.10.1.3 Has a negative consequence for the beneficiary;

2.11.10.1.4 Is auditable; and

2.11.10.1.5 Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.

2.11.10.2 The Contractor shall require all providers to report Provider Preventable Conditions associated with claims for payment or enrollee treatments for which payment would otherwise be made. The Contractor shall report all identified Provider Preventable Conditions to LDH in a format specified by LDH.

2.11.11 Payment for Newborn Care

The Contractor shall cover all newborn care rendered within the first month of life regardless of whether provided by the designated PCP or another network provider. The Contractor shall compensate, at a minimum, ninety percent (90%) of the Medicaid FFS rate in effect for each service coded as a primary care service rendered to a newborn within thirty (30) calendar days of the enrollee's birth regardless of whether the provider is part of the Contractor's network, but subject to the same requirements as a contracted provider.

2.11.12 Payment for Hospital Services

The Contractor is not responsible for reimbursement of graduate medical education (GME) payments or disproportionate share hospital (DSH) payments to providers. The Contractor shall use the increased hospital funds received above the base rate (subject to risk adjustment) to the Full Medicaid Pricing, as detailed in Attachment F, *Actuarial Rate Certification Letter***,** for reimbursement of inpatient and outpatient hospital services.

2.11.13 Payment for Ambulance Services

The Contractor shall use the increased ambulance services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Pricing, as detailed in Attachment F, *Actuarial Rate Certification Letter***,** for reimbursement of ambulance services.

2.11.14 Payment for Physician Services

The Contractor shall use the increased physician services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Pricing, as detailed in Attachment F, *Actuarial Rate Certification Letter*, for reimbursement of physician services.

2.12 Utilization Management

2.12.1 General Requirements

2.12.1.1 The Contractor shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates utilization review and service authorization. The Contractor shall submit written policies and procedures to LDH for approval as part of readiness reviews and sixty (60) calendar days prior to any change.

2.12.1.2 The UM Program policies and procedures shall meet all NCQA standards and include medical management criteria and practice guidelines that:

2.12.1.2.1 Are adopted in consultation with contracted healthcare providers;

2.12.1.2.2 Are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

2.12.1.2.3 Consider the needs of the enrollees; and

2.12.1.2.4 Are reviewed annually and updated periodically as appropriate.

2.12.1.3 The policies and procedures shall include, but not be limited to:

2.12.1.3.1 The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;

2.12.1.3.2 The data sources and clinical review criteria used in decision making;

2.12.1.3.3 The requirement that the appropriateness of clinical review shall be fully documented;

2.12.1.3.4 The process for conducting peer-to-peer reviews of adverse determinations;

2.12.1.3.5 Mechanisms to ensure consistent application of review criteria and compatible decisions;

2.12.1.3.6 Data collection processes and analytical methods used in assessing utilization of healthcare services;

2.12.1.3.7 Provisions for ensuring confidentiality of clinical information;

2.12.1.3.8 Service authorization criteria for specialized behavioral health services that are consistent with state and federal laws, regulations, rules, the State Plan, and waivers applicable to managed care;

2.12.1.3.9 Mechanisms for collaborating with OJJ, DCFS, and DOE to coordinate the discharge and transition of children and youth in out-of-home placement for the continuance of prescribed medication and other behavioral health

services prior to reentry into the community, including the referral to necessary providers or a WAA if indicated;

2.12.1.3.10 Mechanisms for collaborating with hospitals, nursing facilities, intermediate care facilities, residential facilities, and inpatient facilities to coordinate aftercare planning prior to discharge and transition of enrollees for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers; and

2.12.1.3.11 Mechanisms for collaborating with the Department of Corrections and local criminal justice systems in Louisiana to facilitate access to and/or continuation of prescribed medication and other behavioral health services for enrollees, including referral to community providers, prior to reentry into the community including, but not limited to, enrollees in the Medicaid pre-release program.

2.12.1.4 The Contractor shall coordinate the development of specialized behavioral health clinical practice guidelines with other LDH MCOs to avoid providers receiving conflicting practice guidelines from different MCOs. The Contractor shall adopt clinical practice guidelines for the following behavioral health conditions:

2.12.1.4.1 Schizophrenia;

2.12.1.4.2 ADHD;

2.12.1.4.3 Depression;

2.12.1.4.4 Generalized Anxiety Disorder;

2.12.1.4.5 Post-Traumatic Stress Disorder;

2.12.1.4.6 Suicidal Behavior;

2.12.1.4.7 Oppositional Defiant Disorder;

2.12.1.4.8 Bipolar Disorder; and

2.12.1.4.9 Substance Use Disorders.

2.12.1.5 The Contractor shall disseminate the practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

2.12.1.6 The Contractor shall take steps to require adoption of the clinical practice guidelines by specialized behavioral health care providers, and to measure compliance with the guidelines through provider monitoring. The Contractor shall employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.

2.12.1.7 The Contractor shall identify the source of the medical management criteria used for the review of service authorization requests and include:

2.12.1.7.1 The vendor if the criteria was purchased;

2.12.1.7.2 The association if the criteria are developed/recommended or endorsed by a national or state health care provider association or society;

2.12.1.7.3 The guideline source shall be identified if the criteria are based on national best practice guidelines; and

2.12.1.7.4 The individuals who shall make medical necessity determinations if the criteria are based on the medical training, qualifications, and experience of the Contractor's medical director or other qualified and trained professionals.

2.12.1.8 UM Program medical management criteria and practice guidelines shall be posted to the Contractor's website. If the Contractor uses proprietary software that requires a license and which may not be posted publicly according to associated licensure restrictions, the Contractor may post the name of the software only on its website. Upon request by an enrollee, their representative, or LDH, the Contractor shall provide the specific criteria and practice guidelines utilized to make a decision. The Contractor shall make its decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply in a manner consistent with the guidelines.

2.12.1.9 The Contractor shall have written procedures listing the information required from an enrollee or healthcare provider in order to make medical necessity determinations. Such procedures shall be given verbally to the enrollee or provider when requested. The procedures shall outline the process to be followed in the event the Contractor determines the need for additional information not initially requested.

2.12.1.10 The Contractor shall have written procedures to address the failure or inability of a provider or enrollee to provide all the necessary information for review.

2.12.1.11 The Contractor shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines.

2.12.1.12 The Contractor shall make decisions regarding medical necessity using LDH's definition of medically necessary services.

2.12.1.13 The Medicaid Director, in consultation with the Medicaid Medical Director, may require the Contractor to authorize services on a case-by-case basis.

2.12.1.14 The Contractor shall identify in readiness reviews the qualification of staff who will determine medical necessity.

2.12.1.15 Determinations of medical necessity shall be made by qualified and trained practitioners in accordance with state and federal regulations.

2.12.1.16 The Contractor shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of an enrollee's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

2.12.1.17 The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.

2.12.1.18 The individual making these determinations shall attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.

2.12.1.19 The Contractor shall provide a mechanism to reduce inappropriate, duplicative and overuse of health care services.

2.12.1.20 The Contractor shall develop and implement a plan for addressing the long-term stay of enrollees in emergency departments (EDs) based on limited availability for necessary behavioral health services. The plan shall be submitted to LDH for review and approval during readiness reviews. At a minimum, the Contractor's plan shall include:

2.12.1.20.1 Conducting an analysis of use of the ED for behavioral health services, including at a minimum, reason for ED visit, length of stay, inpatient admissions and/or referral to follow-up care, difficulty in accessing follow-up services, and developing recommendations for reducing long term stays in the ED;

2.12.1.20.2 Educating enrollees and providers regarding appropriate utilization of the ED, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate;

2.12.1.20.3 Educating ED staff on availability of community behavioral health resources; and

2.12.1.20.4 Potential impact of additional crisis stabilization beds for children on reducing length of ED stays and plan to increase access to and coordination of crisis services.

2.12.1.21 The Contractor shall conduct utilization management and review functions for the CSoC population. The Contractor shall:

2.12.1.21.1 Apply initial risk screen for CSoC eligibility;

2.12.1.21.2 Refer calls (via a seamless "warm transfer") to the contracted administrator of the CSoC program, who shall apply Brief CANS assessment tool to assess for CSoC presumptive eligibility; and

2.12.1.21.3 Document in the child's health record whether or not (according to CSoC contracted administrator) the child met criteria for CSoC presumed eligibility, when the child was referred to the WAA, and the date on which the Freedom of Choice (FOC) was signed.

2.12.1.22 The Contractor shall also document in the child's health record if the child does not become enrolled in CSoC, for the reasons of 1) the youth and family refuse CSoC services, or 2) the youth does not meet clinical eligibility based on the comprehensive CANS, or 3) for any other reason.

2.12.1.23 For youth who screened positively on the initial risk screen, but who do not complete enrollment in CSoC, the Contractor shall offer voluntary participation in the Case Management Program, and/or other behavioral health services to meet the child and family's presenting needs.

2.12.1.24 Upon request, the Contractor shall provide LDH with documentation supporting how it has placed appropriate limits on a service on the basis of medical necessity for individuals determined by LDH to need specialized behavioral health services.

2.12.1.25 The Contractor shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any enrollee in accordance with 42 C.F.R. §438.3(i) and 42 C.F.R. §422.208.

2.12.1.26 The Contractor shall report fraud and abuse information identified through the UM program to LDH in accordance with 42 C.F.R. §455.1(a)(1).

2.12.1.27 In accordance with 42 C.F.R. §456.111 and §456.211, the Contractor's Utilization Review (UR) plan must provide that each enrollee's record includes information needed for the UR committee to perform UR required under this Section. This information must include, at least, the following:

2.12.1.27.1 Identification of the enrollee;

2.12.1.27.2 The name of the enrollee's physician;

2.12.1.27.3 Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;

2.12.1.27.4 The plan of care required under 42 C.F.R. §456.80 and §456.180;

2.12.1.27.5 Initial and subsequent continued stay review dates described under 42 C.F.R. §456.128, §456.133, §456.233 and §456.234;

2.12.1.27.6 Date of operating room reservation, if applicable; and

2.12.1.27.7 Justification of emergency admission, if applicable.

2.12.2 Medical Records

2.12.2.1 The Contractor shall have a method to verify, by sampling or other methods, on a regular basis that services for which reimbursement was made were provided to enrollees as billed. The Contractor shall have policies and procedures to maintain, or require providers and contractors to maintain, an individual medical record for each enrollee, in accordance with the **MCO Manual**.

2.12.2.2 All documentation and/or records maintained by the Contractor, its material subcontractors, and its network providers related to covered services, charges, operations and agreements under this Contract shall be maintained for at least ten (10) calendar years after the last good, service or supply 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. Under no circumstances shall the Contractor or any of its material subcontractors destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

2.12.3 Utilization Management Committee

2.12.3.1 The Utilization Management (UM) program shall include a UM Committee that integrates with other functional units of the MCO as appropriate and supports the quality assessment and performance improvement program (QAPI) Program as defined in the *Quality Management and Quality Improvement* section.

2.12.3.2 The UM Committee shall provide utilization review and monitoring of UM activities of both the Contractor and its providers and is directed by the Contractor's Medical Director. The UM Committee shall convene no less than quarterly and shall make meeting minutes available to LDH upon request. LDH representatives, as appointed by LDH, shall be included as members of the UM Committee, if requested. UM Committee responsibilities include:

2.12.3.2.1 Monitoring providers' requests for prior authorization of health care services to its enrollees;

2.12.3.2.2 Monitoring the medical appropriateness and necessity of health care services provided to its enrollees utilizing provider quality and utilization profiling data;

2.12.3.2.3 Reviewing the effectiveness of the utilization review process and making changes to the process as needed;

2.12.3.2.4 Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;

2.12.3.2.5 Monitoring consistent application of "medical necessity" criteria;

2.12.3.2.6 Application of clinical practice guidelines;

2.12.3.2.7 Monitoring over- and under-utilization;

2.12.3.2.8 Review of outliers; and

2.12.3.2.9 Medical Record Reviews - reviews of enrollee medical records shall be conducted to ensure that PCPs provide high quality health care that is documented according to established standards.

2.12.4 Medical Record Review Strategy

2.12.4.1 The Contractor shall maintain a written strategy for conducting medical record reviews, reporting results and the corrective action process. The strategy shall be provided to LDH for approval as part of readiness reviews and sixty (60) days prior to any updates. The strategy shall include, at a minimum, the following:

2.12.4.1.1 Designated staff to perform this duty;

2.12.4.1.2 The method of case selection;

2.12.4.1.3 The anticipated number of reviews by practice site;

2.12.4.1.4 The tool the Contractor shall use to review each site;

2.12.4.1.5 How the Contractor shall link the information compiled during the review to other MCO functions (e.g. quality improvement (QI), credentialing, peer review, etc.); and

2.12.4.1.6 Schedule of reviews by provider type.

2.12.4.2 The standards, which shall include all medical record documentation requirements addressed in the Contract, shall be distributed to all providers.

2.12.4.3 The Contractor shall conduct reviews at all PCP sites with fifty (50) or more linked enrollees and practice sites which include both individual offices and large group facilities. The Contractor shall review each site at least one (1) time during each two (2) year period.

2.12.4.4 The Contractor shall review a reasonable number of records at each site to determine compliance. Five (5) to ten (10) records per site is a generally accepted target. For large group practices (six (6) or more providers in the group), three (3) record reviews per provider shall be required.

2.12.4.5 The Contractor shall report the results of all medical record reviews to LDH quarterly with an annual summary.

2.12.5 Utilization Management Reports

The Contractor shall submit utilization management reports as specified by LDH. LDH reserves the right to request additional reports as deemed necessary. LDH will notify the

Contractor of additional required reports no less than sixty (60) calendar days prior to the due date of those reports.

2.12.6 Service Authorization

2.12.6.1 The Contractor shall have service authorization policies and procedures for prior authorization, concurrent authorization, and post authorization that comply with 42 C.F.R. §438.210 and any court-ordered requirements. For pharmacy service authorizations, see the **MCO Manual**. Policies and procedures shall include, but are not limited to, the following:

2.12.6.1.1 Written policies and procedures for processing requests for initial and continuing authorizations of services;

2.12.6.1.2 Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;

2.12.6.1.3 Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease;

2.12.6.1.4 Process to arrange for another level of care if appropriate when the Contractor denies a service authorization request;

2.12.6.1.5 If the Contractor denies a claim, in whole or in part, or a request for a service authorization based upon medical management criteria and/or clinical practice guidelines, the Contractor shall provide to the healthcare provider submitting the claim or the request for authorization a written copy of the specific medical management criteria and/or clinical practice guidelines utilized to make the decision at the same time the Contractor notifies the provider of the decision and shall not refuse to provide such information on the grounds that it is proprietary; and

2.12.6.1.6 Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its enrollee manual and incorporated in the grievance procedures.

2.12.6.2 The Contractor's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers.

2.12.6.3 The Contractor's service authorization system shall have capacity to electronically store and report the time and date all service authorization requests are received, decisions made by the Contractor regarding the service requests, clinical data to support the decision, and time frames for notification of providers and enrollees of decisions.

2.12.6.4 The Contractor shall not deny continuation of higher-level services (e.g., inpatient hospital) for failure to meet medical necessity unless the Contractor can provide the service through an in-network or out-of-network provider at a lower level of care.

2.12.6.4.1 If placement at a lower level of care was delayed by DCFS, the Contractor may invoice DCFS for its expense incurred for continuation of higher-level services.

2.12.6.5 The Contractor shall utilize a common hospital observation policy that is developed and maintained collectively by MCO personnel with approval of LDH. The common hospital observation policy shall be reviewed annually by the MCOs in its entirety. Any revisions shall be reviewed and approved by LDH at least thirty (30) calendar days prior to implementation.

2.12.6.6 The Contractor shall perform prior authorization and concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals.

2.12.6.7 The Contractor shall ensure that inpatient psychiatric hospital and concurrent utilization reviews are completed by a Licensed Mental Health Professional (LMHP) for each enrollee referred for psychiatric admissions to general hospitals. The Contractor shall comply with the requirements set forth in state administrative rules.

2.12.7 Pre-screen for PRTF

2.12.7.1 When a referring party requests PRTF for an enrollee, the Contractor shall perform an initial screen upon receipt of referral including review of records and current clinical information to determine whether PRTF is an appropriate level of care, or if alternate community-based services could meet the referral needs. The screen shall be completed within twenty-four (24) hours of the Contractor's receipt of the referral and all clinical information needed and requested by the Contractor to make the determination.

2.12.7.2 Upon completion of the screen, if the PRTF is approved, the Contractor shall immediately notify the enrollee and/or guardian and, with consent, the referring party requesting PRTF services and, within forty-eight (48) hours, provide written notification of the approval. The Contractor shall also then generate a Prior Authorization for each PRTF admission within forty-eight (48) hours of completion of the screen. In consultation with the enrollee's guardian and referring party, the Contractor shall locate a PRTF provider appropriate to meet the enrollee's needs with availability to admit the enrollee. Given the need to locate an appropriate PRTF provider with bed availability in a timely manner, the Contractor shall maintain near real time bed utilization/availability for network PRTFs and out-of-network replacements. When the initial screen results in a determination that the member is in need of PRTF care, the Contractor shall secure admission to an appropriate PRTF for the enrollee within the timeframe stated in Attachment D, in compliance with access and availability standards for this level of care.

2.12.7.3 If PRTF placement is denied, the Contractor shall immediately notify the enrollee and/or guardian and, with consent, the referring party requesting PRTF services and,

within forty-eight (48) hours, provide written notification of the denial. The notification of denial shall include information on alternative services that may meet the enrollee's needs to ensure health and safety, including information on available providers of those services, the right of the enrollee to appeal the denial, and the process to do so.

2.12.7.4 For youth pending release from a secure setting for whom a PRTF is being requested, the Contractor is required to complete the screen prior to the youth's release if it is anticipated that the youth will be re-linked to the Contractor following release.

2.12.8 Certification of Need (CON) for PRTFs

2.12.8.1 The Contractor shall comply with the requirements set forth at 42 C.F.R. Part 441, Subpart D.

2.12.8.2 The Contractor shall ensure LMHPs are included in the team responsible for certification and recertification of PRTF services in Louisiana. This shall include a face-to-face assessment by an LMHP or a telephonic/video consultation with an LMHP who has had a face-to-face interview with the child/youth, in addition to the recommendations of the team specified at 42 C.F.R. §441.156.

2.12.8.3 The Contractor may use an LMHP/team composed of Contractor staff or subcontracted LMHPs. To ensure the team has knowledge of the ambulatory resources available to the youth and the youth's situation, the Contractor shall ensure that the team is assembled by a subcontract in the child's/youth's parish of residence or adjacent parish (if not in state custody) or the child's/youth's parish or adjacent parish of responsibility (if in state custody).

2.12.8.4 For youth pending release from a secure setting for whom a PRTF is being requested, the Contractor is required to coordinate the completion of the CON prior to the youth's release if it is anticipated that the youth shall be re-linked to the Contractor following release.

2.12.8.5 Recertification of the stay shall occur every sixty (60) calendar days. For the PRTF screens to be complete, the team shall meet and rule out other community based options. This does not apply to other inpatient screens.

2.12.8.6 In addition to the pre-screen and certifying the need, the Contractor shall:

2.12.8.6.1 Be responsible for tracking the enrollee's authorization period for PRTF stays and providing notification to the responsible party when a recertification is due;

2.12.8.6.2 Ensure that PRTF certification, including the independent certification, are forwarded to the admitting facility;

2.12.8.6.3 Accurately determine admissions and discharges to PRTFs and perform PRTF-specific eligibility functions; and

2.12.8.6.4 Work with the Medicaid FI to determine retroactive eligibility and assignment, when applicable.

2.12.9 Timing of Service Authorization Decisions

2.12.9.1 Standard Service Authorization

2.12.9.1.1 The Contractor shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination, with the exception of authorizations for CPST and PSR services for which the standard for determination is within five (5) calendar days of obtaining appropriate medical information. All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.

2.12.9.1.2 The service authorization decision may be extended up to fourteen (14) additional calendar days if:

2.12.9.1.2.1 The enrollee, or the provider, requests the extension; or

2.12.9.1.2.2 The Contractor justifies (to LDH upon request) a need for additional information and how the extension is in the enrollee's interest.

2.12.9.1.3 The Contractor shall make ninety-five percent (95%) of concurrent review determinations within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required.

2.12.9.2 Expedited Service Authorization

2.12.9.2.1 In the event a provider indicates, or the Contractor determines, that following the standard service authorization timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.

2.12.9.2.2 The Contractor may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the enrollee requests the extension or if the Contractor justifies to LDH a need for additional information and how the extension is in the enrollee's best interest.

2.12.9.3 Post Authorization

2.12.9.3.1 The Contractor shall make retrospective review determinations within thirty (30) calendar days of obtaining the results of any appropriate medical

information that may be required, but in no instance later than one hundred eighty (180) calendar days from the date of receipt of request for service authorization.

2.12.9.3.2 The Contractor 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.

2.12.9.3.3 The Contractor shall not use a policy with an effective date subsequent to the original service authorization request date to rescind its prior authorization.

2.12.9.4 Timing of Notice

2.12.9.4.1 Notice of Action

2.12.9.4.1.1 Approval

- For service authorization approval for a non-emergency admission, procedure or service, the Contractor shall provide written notification to the provider within two (2) business days of making the determination.

- For service authorization approval for extended stay or additional services, the Contractor shall provide written notification to the provider within two (2) business days of making the determination.

2.12.9.4.1.2 Adverse Action

- The Contractor shall notify the enrollee, in writing using language that is easily understood by the enrollee, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in the *Enrollee Grievances, Appeals and State Fair Hearings* section. The notice of action to enrollees shall be consistent with requirements in 42 C.F.R. §438.404, §438.10 and §438.210, the *Marketing and Education* section for member written materials, and any agreements that the Department may have entered into relative to the contents of enrollee notices of denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out-of-court settlements.

- The Contractor shall notify the requesting provider of a decision to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. The Contractor shall provide written notification to the provider rendering the service, whether a health care professional or facility or both, within two (2) business days of

making the determination.

2.12.9.4.1.3 Informal Reconsideration

- As part of the Contractor's appeal procedures, the Contractor shall include an Informal Reconsideration process that allows the enrollee (or provider/agent on behalf of a enrollee) a reasonable opportunity to present evidence, and allegations of fact or law, in person and in writing.

- In a case involving an initial determination or a concurrent review determination, the Contractor shall provide the enrollee or a provider acting on behalf of the enrollee and with the enrollee's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [42 C.F.R. §438.402(c)(1)(ii)].

- The informal reconsideration shall occur within one (1) business day of the receipt of the request and shall be conducted between the provider rendering the service and the Contractor's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) business day.

- The Informal Reconsideration does not extend the thirty (30) calendar day required timeframe for a Notice of Appeal Resolution.

2.12.10 Exceptions to Requirements

2.12.10.1 The Contractor shall not require service authorization for emergency services or post-stabilization services as described in this Section whether provided by an in-network or out-of-network provider.

2.12.10.2 The Contractor shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.

2.12.10.3 The Contractor shall not require service authorization or referral for EPSDT screening services.

2.12.10.4 The Contractor shall not require service authorization for the continuation of medically necessary covered services of a new enrollee transitioning to the Contractor, regardless of whether such services are provided by an in-network or out-of-network provider, however, the Contractor may require prior authorization of services beyond thirty (30) calendar days.

2.12.10.5 The Contractor is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first thirty (30) calendar days of a new enrollee's linkage to the Contractor's plan.

2.12.10.6 The Contractor shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the Contractor for routine and preventive women's health care services and prenatal care.

2.12.10.7 The Contractor shall not require a PCP referral for in-network eye care and vision services.

2.12.10.8 The Contractor may require notification by the provider of obstetrical care at the time of the first visit of the pregnancy.

2.12.10.9 The Contractor may require notification by the provider of obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery. The Contractor is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of Obstetrical admission exceeding forty-eight (48) hours after vaginal delivery. In this case, the Contractor may only deny the portion of the claim related to the inpatient stay beyond forty-eight (48) hours.

2.12.10.10 The Contractor may require notification by the provider of Obstetrical admissions exceeding ninety-six (96) hours after Caesarean section. The Contractor is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of Obstetrical admission exceeding ninety-six (96) hours after Caesarean section. In this case, the Contractor may only deny the portion of the claim related to the inpatient stay beyond ninety-six (96) hours.

2.12.11 Medical History Information

2.12.11.1 The Contractor is responsible for eliciting pertinent medical record information from the treating health care provider(s), as needed and/or as requested by LDH, for purposes of making medical necessity determinations.

2.12.11.2 The Contractor shall take appropriate action when a treating health care provider does not provide complete medical history information within the requested timeframe.

2.12.11.3 The Contractor shall not be required to pay for a particular item or service when the provider does not provide requested medical information for purposes of making medical necessity determinations, for that particular item or service.

2.12.11.4 When the provider fails to provide medical record information, the Contractor may at its discretion, or shall as directed by LDH, impose financial penalties against the provider as appropriate.

2.12.12 PCP and Behavioral Health Provider Utilization and Quality Profiling

2.12.12.1 The Contractor shall, at a minimum, profile its PCPs and specialized behavioral health providers (including but not limited to addiction, mental health, and residential providers) and analyze utilization data to identify utilization and/or quality of care issues.

2.12.12.2 The Contractor shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.

2.12.13 Court-Ordered Assessment, Treatment, and Placement which Challenge Medical Necessity Determination and Defensible Lengths of Stay

All court-ordered Medicaid behavioral health services are subject to medical necessity review. In order for the service to be eligible for payment, the Contractor shall determine that the service is medically necessary and a covered service.

2.13 Enrollee Services

2.13.1 Enrollees' Rights and Responsibilities

2.13.1.1 The Contractor shall have written policies regarding enrollee rights and responsibilities. The Contractor shall comply with all applicable state and federal laws pertaining to enrollee rights and privacy. The Contractor shall further ensure that the Contractor's employees, subcontractors and MCO providers consider and respect those rights when providing services to enrollees.

2.13.1.2 The rights afforded to current enrollees are detailed in the **MCO Manual**.

2.13.1.3 The Contractor shall encourage each enrollee to be responsible for his/her own health care by becoming an informed and active participant in his/her care. Enrollees have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate medical and personal histories, being present at scheduled appointments and reporting on treatment progress, such as notifying his/her health care provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.

2.13.1.4 The Contractor shall inform members of their responsibilities which shall include but are not limited to:

- Informing the MCO of the loss or theft of their ID card;
- Presenting their MCO ID card when using health care services;
- Being familiar with the MCO procedures to the best of the member's abilities;
- Calling or contacting the MCO to obtain information and have questions answered;

- Providing participating network providers with accurate and complete medical information;

- Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible;

- Living healthy lifestyles and avoiding behaviors known to be detrimental to their health;

- Following the grievance system established by the MCO if they have a disagreement with a provider; and

- Making every effort to keep any agreed upon appointments and follow-up appointments, accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.

2.13.2 Required Materials and Services

2.13.2.1 The Contractor shall ensure materials do not discriminate against enrollees on the basis of their health history, health status or need for health care services. This applies to enrollment, re-enrollment or disenrollment materials and processes from the Contractor.

2.13.2.2 The Contractor shall adhere to the requirements and procedures regarding the justice-involved pre-release population as set forth in the **MCO Manual**.

2.13.2.3 The Contractor shall adhere to the requirements for the Member Handbook, Welcome Member Newsletter, ID card, and Provider Directory as specified in this Contract, its attachments, and in accordance with 42 C.F.R. §438.10.

2.13.3 Welcome Packets

2.13.3.1 The Contractor shall send a welcome packet to new enrollees within ten (10) business days from the date of receipt of the ANSI ASC X12 834 file identifying the new enrollee. ID cards must be mailed within ten (10) business days.

2.13.3.2 When the name of the responsible party for the new enrollee is associated with two (2) or more new enrollees in the same eligibility group (see *Eligibility and Enrollment* section), the Contractor is only required to send one (1) welcome packet. If enrollees are in different eligibility groups that equate to different levels of coverage, separate welcome packets for each type of coverage shall be sent.

2.13.3.3 All contents of the welcome packet are considered member materials and, as such, shall be reviewed and subject to written approval by LDH prior to distribution according to the provisions described in this Contract. Contents of the welcome

packets shall include those items specified in the Contract. The welcome packet shall include, but is not limited to:

2.13.3.3.1 A Member Handbook and/or Welcome Member Newsletter;

2.13.3.3.2 The MCO Member ID Card (if not mailed under a separate mailing);

2.13.3.3.3 If the Member ID Card is mailed separately, a welcome letter highlighting major program features, details that a card specific to the MCO shall be sent via mail separately, and contact information for the MCO; and

2.13.3.3.4 A current provider directory when specifically requested by the member (also must be available in searchable format online).

2.13.4 Welcome Calls

2.13.4.1 The Contractor shall make welcome calls to new enrollees within fourteen (14) business days of the date the Contractor sends the welcome packet.

2.13.4.2 The Contractor shall review PCP assignment if an automatic assignment was made and assist the enrollee in changing the PCP if requested by the enrollee.

2.13.4.3 The Contractor shall develop and submit to LDH for approval a script(s), for all covered populations as specified in the *Eligibility and Enrollment* section to be used during the welcome call to discuss the following information with the enrollee:

2.13.4.3.1 A brief explanation of the program;

2.13.4.3.2 Statement that all enrollee PHI shall be handled in accordance with federal privacy laws;

2.13.4.3.3 The availability of oral interpretation and written translation services and how to obtain them free of charge;

2.13.4.3.4 The concept of the patient-centered medical home, including the importance of the enrollee(s) making a first appointment with his or her PCP for preventive care before the enrollee requires care due to an illness or condition and instructions about changing PCPs; and

2.13.4.3.5 Administration of the Health Needs Assessment with a focus on criteria to establish the appropriate tier of case management as described in the *Care Management* section.

2.13.4.4 The Contractor shall make three (3) attempts to contact the enrollee. If the Contractor discovers that the enrollee lost or never received the welcome packet, the Contractor shall resend the packet.

2.13.5 Member Materials and Programs for Current Enrollees

The Contractor shall develop and distribute member educational materials, including but not limited to, the following:

2.13.5.1 A member-focused website which can be a designated section of the MCO's general informational website, and interactive media content such as a mobile device application, a mobile optimized website, or interactive social media;

2.13.5.2 Bulletins or newsletters distributed not less than two (2) times per calendar year that provide information on preventive care, access to PCPs and other providers, and other information that is helpful to members;

2.13.5.3 Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the Contractor. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;

2.13.5.4 Targeted brochures, posters and pamphlets to address issues associated with enrollees with chronic diseases and/or special heath care needs;

2.13.5.5 Materials focused on health promotion programs available to the enrollees;

2.13.5.6 Communications detailing how enrollees can take personal responsibility for their health and self-management;

2.13.5.7 Materials that promote the availability of health education classes for enrollees;

2.13.5.8 Materials that provide education for enrollees with, or at risk for, a specific disability or illness;

2.13.5.9 Materials that provide education to enrollees, enrollees' families and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities;

2.13.5.10 Notification to its enrollees of their right to request and obtain the welcome packet (including all items noted in this section except for the Member ID card) at least once a year;

2.13.5.11 Notification to its members of any change that LDH defines as significant at least thirty (30) calendar days before the intended effective date; and

2.13.5.12 All materials distributed must comply with the relevant guidelines established by LDH for these materials and/or programs.

2.13.6 MCO Member Handbook

2.13.6.1 The Contractor shall provide each enrollee a member handbook, utilizing the State developed model enrollee handbook in the **MCO Manual**, to serve as a summary of benefits and coverage, within a reasonable time after receiving notice of the beneficiary's enrollment. [42 C.F.R. §438.10]

2.13.6.2 At a minimum, the member handbook shall include the following information, as applicable to the covered population that is the audience for the handbook, that enables the enrollee to understand how to effectively use the managed care program:

2.13.6.2.1 Table of contents;

2.13.6.2.2 A general description about how the MCO operates, and detailed descriptions of the following: enrollee rights and responsibilities, appropriate utilization of services including ED for non-emergent conditions, behavioral health services available, a description of the PCP selection process, the PCP's role as coordinator of services, and an explanation of how the enrollee can access LDH's policy on how to receive continued services during a termination of an MCO contract or disenrollment from an MCO as required by 42 C.F.R. §438.62;

2.13.6.2.3 Enrollee's right to disenroll from the MCO including disenrollment for cause;

2.13.6.2.4 Enrollee's right to select and change PCPs within the MCO and how to do so;

2.13.6.2.5 Any restrictions on the enrollee's freedom of choice among MCO providers;

2.13.6.2.6 Enrollee's rights and protections, as specified in 42 C.F.R. §438.100 and this Contract;

2.13.6.2.7 The amount, duration, and scope of benefits available to the enrollee under the contract between the MCO and LDH in sufficient detail to ensure that enrollees understand the benefits to which they are entitled, including specialized behavioral health benefits and information about health education and promotion programs, including chronic care management, tobacco cessation, and problem gaming;

2.13.6.2.8 Procedures for obtaining benefits, including authorization requirements;

2.13.6.2.9 Description on the purpose of the Medicaid card and the MCO card and why both are necessary and how to use them;

2.13.6.2.10 The extent to which, and how, enrollees may obtain benefits, including family planning services from out-of-network providers. An explanation shall be included that explains that the MCO cannot require the enrollee to obtain a referral before choosing a family planning provider;

2.13.6.2.11 The extent to which, and how, after-hours, crisis and emergency coverage are provided, including:

- What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 C.F.R. §438.114(a);

- That prior authorization is not required for emergency services;

- The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent;

- The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered by the MCO; and

- That, subject to the provisions of 42 C.F.R. Part 438, the enrollee has a right to use any hospital or other setting for emergency care.

2.13.6.2.12 The post-stabilization care services rules set forth in 42 C.F.R. §422.113(c);

2.13.6.2.13 Policy on referrals for specialty care, including specialized behavioral health services and for other benefits not furnished by the enrollee's PCP;

2.13.6.2.14 How and where to access any benefits that are available under the Louisiana Medicaid State Plan, but are not covered under the MCO's contract with LDH;

2.13.6.2.15 That the enrollee has the right to refuse to undergo any medical service, or treatment or to accept any health service provided by the MCO if the enrollee objects (or in the case of a child, if the parent or guardian objects) on religious grounds;

2.13.6.2.16 For counseling or referral services that the MCO does not cover because of moral or religious objections, the MCO shall direct the enrollee to contact the enrollment broker for information on disenrollment procedures;

2.13.6.2.17 Enrollee grievance, appeal, and state fair hearing procedures and time frames, as described in 42 C.F.R. Part 438, Subpart F and this Contract;

2.13.6.2.18 Grievance, appeal, and state fair hearing procedures that include the following:

2.13.6.2.18.1 For State Fair Hearing:

- The right to a hearing;

- The method for obtaining a hearing; and

- The rules that govern representation at the hearing.

2.13.6.2.18.2 The right to file grievances and appeals;

2.13.6.2.18.3 The requirements and timeframes for filing a grievance or appeal;

2.13.6.2.18.4 The availability of assistance in the filing process;

2.13.6.2.18.5 The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone;

2.13.6.2.18.6 The fact that, when requested by the enrollee:

- Benefits will continue if the enrollee files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and

- The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.

2.13.6.2.18.7 In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of the LDH who has final authority to determine whether services shall be provided.

2.13.6.2.19 Advance Directives, as set forth in 42 C.F.R. §438.3(j). A description of advance directives which shall include:

2.13.6.2.19.1 The MCO policies related to advance directives;

2.13.6.2.19.2 The enrollee's rights under Louisiana state law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change;

2.13.6.2.19.3 Information on how enrollees can file complaints about the failure to comply with an advance directive with the LDH Health Standards Section, Louisiana's Survey and Certification agency; and

2.13.6.2.19.4 Information about where an enrollee can seek assistance in executing an advance directive and to whom copies should be given.

2.13.6.2.20 Information on how to call the Medicaid Customer Service Unit toll-free hotline, visit the Louisiana Medicaid website, or visit a regional Medicaid eligibility office to report any changes to demographic or other information which may affect eligibility;

2.13.6.2.21 Information on how to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";

2.13.6.2.22 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;

2.13.6.2.23 The toll-free telephone number for medical management;

2.13.6.2.24 How to obtain emergency and non-emergency medical transportation, including transportation for any benefits carved out of the MCO contract and provided by the State;

2.13.6.2.25 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and how to access component services if individuals under age 21 entitled to the EPSDT benefit are enrolled with the MCO;

2.13.6.2.26 How and where to access any benefits provided by the State, including EPSDT benefits delivered outside the MCO, if any;

2.13.6.2.27 Information about cost sharing on any benefits carved out of the MCO contract and provided by the State;

2.13.6.2.28 Information about the requirement that a enrollee shall notify the MCO immediately if he or she has a Worker's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in an auto accident;

2.13.6.2.29 Reporting requirements for the enrollee that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported to the MCO;

2.13.6.2.30 Enrollee responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the MCO or LDH. This shall include a statement that the enrollee is responsible for protecting their ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the enrollee's Medicaid eligibility and/or legal action;

2.13.6.2.31 Instructions on how to access auxiliary aids and services, including interpretation and translation in alternative formats and languages when needed at no cost to the enrollee. This instruction shall be included in all versions of the handbook in English and Spanish;

2.13.6.2.32 Information on the enrollee's right to a second opinion in accordance with 42 C.F.R. §438.206(b)(3) at no cost and how to obtain it;

2.13.6.2.33 Ways to report suspected provider fraud and abuse including, but not limited to, using the LDH and MCO toll-free numbers and website established for that purpose;

2.13.6.2.34 Any additional text provided to the MCO by LDH or deemed essential by the MCO;

2.13.6.2.35 The date of the last revision;

2.13.6.2.36 Additional information that is available upon request, including the following:

2.13.6.2.36.1 Information on the structure and operation of the MCO;

2.13.6.2.36.2 Physician incentive plans [42 C.F.R. §438.3(i)].

2.13.6.2.36.3 Service utilization policies; and

2.13.6.2.36.4 How to report alleged marketing violations to LDH utilizing the **Marketing Complaint Form,** which can be found in the Procurement Library.

2.13.6.2.37 Information regarding specialized behavioral health services, including but not limited to:

2.13.6.2.37.1 A description of covered behavioral health services;

2.13.6.2.37.2 Where and how to access behavioral health services and behavioral health providers;

2.13.6.2.37.3 General information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult engagement; resilience; strength-based and evidence-based practice; and best/proven practices;

2.13.6.2.37.4 Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and

2.13.6.2.37.5 Any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment as per 42 C.F.R. Part 2.

2.13.6.2.38 Information on what to do if an enrollee is billed, and under what circumstances an enrollee may be billed for non-MCO covered services;

2.13.6.3 The information specified in this Section will be considered to be provided if the MCO:

2.13.6.3.1 Mails a printed copy of the information to the enrollee's mailing address;

2.13.6.3.2 Provides the information by email after obtaining the enrollee's agreement to receive the information by email;

2.13.6.3.3 Posts the information on their member website and advises the enrollee in paper or electronic form that the information is available at the specified web address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or

2.13.6.3.4 Provides the information in any other method that can reasonably be expected to result in the enrollee receiving the information.

2.13.6.4 At least once a year, the Contractor shall notify the enrollee of their option of receiving either the Member Handbook or the member Welcome Newsletter in either electronic format or hardcopy, upon request from the enrollee.

2.13.6.5 The Contractor shall review and update the Member Handbook at least once a year. The Handbook shall be submitted to LDH for approval at least four (4) weeks prior to the annual open enrollment period and upon any changes prior to being made available to enrollees.

2.13.6.6 MCO Welcome Newsletter

2.13.6.6.1 Should the Contractor elect not to provide a Member Handbook hard copy at the time of sending the welcome packet for new enrollees, the Contractor shall develop and maintain a welcome newsletter that adheres to the requirements in 42 C.F.R. §438.10.

2.13.6.6.2 The Contractor shall review and update the Welcome Member Newsletter at least once a year. The Newsletter must be submitted to LDH for approval at least four (4) weeks prior to the annual open enrollment period and upon any changes prior to being made available to enrollees.

2.13.6.6.3 At a minimum, each welcome newsletter shall include the following information as it applies to the covered populations as specified in the *Eligibility and Enrollment* section:

2.13.6.6.3.1 Right to request an updated Member Handbook at no cost to the enrollee. Notification that the Handbook is available on the Contractor's website, by electronic mail or through postal mailing must be referenced;

2.13.6.6.3.2 Enrollee Grievance and Appeal rights;

2.13.6.6.3.3 Right to access oral interpretation services, free of charge, and how to access them that adheres to the requirements in 42 C.F.R. §438.10(d)(4) and (5);

2.13.6.6.3.4 MCO service hours and availability with contact information including, but not limited to, Member Services, Nurse Line, Behavioral Health Crisis Line, Reporting suspected Fraud and Abuse, Pharmacy Benefits Manager, and any subcontractor providing MCO covered services or value-added benefits;

2.13.6.6.3.5 Tobacco Cessation Information with a website link to tobacco education and prevention program;

2.13.6.6.3.6 Information on how to search for providers, including specialized behavioral health providers, and how to obtain, at no charge, a directory of providers;

2.13.6.6.3.7 Information regarding the circumstances under which an enrollee may be billed for non-MCO covered services;

2.13.6.6.3.8 What to do in case of an emergency, information on proper emergency service utilization, and the right to obtain emergency services at any hospital or other ED facility, in or out-of-network;

2.13.6.6.3.9 Description of fraud, waste, and abuse, including instruction on how to report suspected fraud, waste, and abuse;

2.13.6.6.3.10 Right to be treated fairly regardless of race, religion, gender identity, age, sexual orientation, and ability to pay;

2.13.6.6.3.11 Right to request a medical record copy and/or inspect medical records at a reasonable, cost-based fee as specified in 45 C.F.R. 164.524;

2.13.6.6.3.12 How to access afterhours care;

2.13.6.6.3.13 How to change Health Plans;

2.13.6.6.3.14 Instructions on changing your PCP;

2.13.6.6.3.15 Instructions on where to find detailed listing of covered benefits;

2.13.6.6.3.16 Identification of services for which copays are applicable;

2.13.6.6.3.17 Specialized behavioral health services information, including where and how to access behavioral health services (including emergency or crisis services); and

2.13.6.6.3.18 Problem gambling treatment with a website link to resources.

2.13.7 Member Identification (ID) Cards

2.13.7.1 Enrollees shall be issued at a minimum two (2) different member ID cards related to their enrollment in the Louisiana Medicaid managed care program. The Contractor may opt to provide members with a third ID card, if the Contractor elects to issue a separate pharmacy-related ID card.

2.13.7.2 The Contractor shall mail the member ID cards to new enrollees within ten (10) business days from the date of receipt of the ANSI ASC X12 834 file identifying the new enrollee.

2.13.7.3 A LDH issued ID card shall be issued to all Medicaid beneficiaries, including MCO members. This card is not proof of eligibility, but can be used for accessing the State's electronic eligibility verification systems by MCO providers. These systems will contain the most current information available to LDH, including specific information regarding MCO enrollment. There will be no MCO specific information printed on the card. The enrollee may need to show this card to access Medicaid services not included in the MCO covered services.

2.13.7.4 The Contractor shall design and, upon approval by LDH, produce, and distribute member ID cards. The MCO-issued member ID card shall contain information specific to the MCO and be easily and readily distinguishable from all other insurance products operated by the Contractor or its parent corporation. The member's ID card shall at a minimum include, but not be limited to, the following information as it applies to the covered populations as specified in the *Eligibility and Enrollment* section:

2.13.7.4.1 The member's name and date of birth;

2.13.7.4.2 The MCO's name and address;

2.13.7.4.3 Instructions for emergencies;

2.13.7.4.4 The PCP's name and telephone numbers (including after-hours number, if different from business hours number); and

2.13.7.4.5 The toll-free number(s) for:

2.13.7.4.5.1 24-hour Nurse Line;

2.13.7.4.5.2 Member Services Line;

2.13.7.4.5.3 Filing Grievances;

2.13.7.4.5.4 24-hour behavioral health crisis line;

2.13.7.4.5.5 Provider Services and Prior Authorization; and

2.13.7.4.5.6 Reporting Medicaid Fraud (1-800-488-2917).

2.13.7.5 The Contractor may provide the MCO Member ID 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 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.

2.13.7.6 The card shall be issued without the PCP information if no PCP selection has been made as of the date of the mailing.

2.13.7.7 Once PCP 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.

2.13.7.8 The Contractor shall reissue the member ID card within ten (10) calendar days of notice that an enrollee reports a lost card, there is an enrollee name change, the PCP

changes, or for any other reason that results in a change to the information on the member ID card.

2.13.7.9 The holder of the member identification card issued by the Contractor shall be an MCO member or guardian of a member. If the Contractor has knowledge of any MCO member permitting the use of this identification card by any other person, the Contractor shall immediately report this violation to the Medicaid Fraud Hotline number: 1-800-488-2917.

2.13.7.10 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.

2.13.7.11 Pharmacy-Related ID Card Requirements

2.13.7.11.1 The Contractor shall provide on the member's identification card, or on a separate prescription benefit card, or through other technology, prescription billing information that:

2.13.7.11.1.1 Complies with the standards set forth in the National Council for Prescription Drug Programs pharmacy ID card prescription benefit card implementation guide at the time of issuance of the card or other technology; or

2.13.7.11.1.2 Includes, at a minimum, the following data elements:

- The name or identifying trademark of the MCO and the prescription benefit manager (see co-branding restrictions in the *Marketing and Education* section);
- The name and MCO member identification number of the enrollee;
- The telephone number that providers may call for:
  - Pharmacy benefit assistance;
  - 24-hour member services and filing grievances;
  - Provider services and prior authorization; and
  - Reporting Medicaid Fraud.
- All electronic transaction routing information and other numbers required by the Contractor or its benefit administrator to process a prescription claim electronically.

2.13.7.11.1.3 If the Contractor chooses to include the prescription benefit information on the member ID card, the Contractor shall ensure all

enrollees have a card that includes all necessary prescription benefit information, as outlined above.

2.13.7.11.1.4 If the Contractor chooses to provide a separate prescription benefit card, the card mailer that accompanies the card shall include language that explains the purpose of the card, how to use the card and how to use it in tandem with the LDH-issued Medicaid Card and the MCO-issued member ID card.

2.13.8 Provider Directory for Members

2.13.8.1 The Contractor shall develop and maintain a Provider Directory in three (3) formats:

2.13.8.1.1 A hard copy directory, a copy of which shall be provided to enrollees and potential enrollees upon request;

2.13.8.1.2 Web-based searchable, web-based machine readable, online directory for enrollees and the public; and

2.13.8.1.3 Electronic file of the directory to be submitted and updated weekly to the Medicaid FI, the enrollment broker, or other designee as determined by LDH.

2.13.8.2 The Contractor shall submit templates of its provider directory to LDH as part of readiness reviews.

2.13.8.3 The hard copy directory for enrollees shall be revised with updates at least monthly or no more than thirty (30) calendar days after the receipt of updated provider information. Inserts may be used to update the hard copy directories monthly to fulfill requests by enrollees and potential enrollees. The web-based online version shall be updated in real time, but no less than weekly.

2.13.8.4 In accordance with 42 C.F.R. §438.10(h), the provider directory shall include, but not be limited to:

2.13.8.4.1 Names, group affiliations, street addresses, telephone numbers, website URLs, specialties, whether the provider is accepting new enrollees, and cultural and linguistic capabilities by current contracted providers by each provider type specified in this Contract. Cultural and linguistic capabilities shall include languages offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competency training. The provider directory shall also indicate whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment;

2.13.8.4.2 Identification of qualified providers divided into specific provider and service types and specializations, including but not limited to, primary care physicians, specialists, hospital PCP groups, pharmacies, behavioral health providers, clinic settings, home and community-based services, outpatient therapy, residential substance use, youth residential services, inpatient

mental health and residential substance use services, and FQHCs and RHCs in the service area. This shall include a child serving list that is both monitored and frequently updated to ensure viable options are identified and available for OJJ, DCFS and LDOE field staff. The MCO provider types shall be delineated by parish and zip code;

2.13.8.4.3 Identification of any restrictions on the enrollee's freedom of choice among network providers; and

2.13.8.4.4 Identification of hours of operation including identification of providers with non-traditional hours (before 8 a.m. or after 5 p.m. or any weekend hours).

2.13.8.4.5 LDH reserves the right to request additional data needed for enhancements to the provider search function.

2.13.9 Notice to Enrollees of Provider Termination

2.13.9.1 The Contractor shall give written notice of a provider's termination to each enrollee who had a provider-beneficiary relationship with the provider in the past twelve (12) months. When timely notice from the provider is received, the notice to the enrollee shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.

2.13.9.2 The Contractor shall provide notice to an enrollee, or the parent/legal guardian and the involved state agency as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven (7) calendar days from the date the Contractor becomes aware of such, if it is prior to the change occurring.

2.13.9.3 Failure to provide notice prior to the dates of termination shall 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 Contractor, 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 Contractor becoming aware of the circumstances.

2.13.10 Member Call Center

2.13.10.1 The Contractor shall maintain a toll-free member service call center, physically located in the United States, with dedicated staff to respond to member questions including, but not limited to, such topics as:

2.13.10.1.1 Explanation of MCO policies and procedures;

2.13.10.1.2 Prior authorizations;

2.13.10.1.3 Access information;

2.13.10.1.4 Information on PCPs or specialists;

2.13.10.1.5 Referrals to participating specialists;

2.13.10.1.6 Resolution of service and/or medical or behavioral health delivery problems;

2.13.10.1.7 Enrollee rights and responsibilities;

2.13.10.1.8 Coordination of support services available through Medicaid or community organizations;

2.13.10.1.9 Enrollee grievances; and

2.13.10.1.10 Information on Specialized Behavioral Health Services and Providers.

2.13.10.2 The toll-free number must be staffed between the hours of 7 a.m. and 7 p.m. Central Time, Monday through Friday, excluding Louisiana state designated holidays.

2.13.10.3 The toll-free line shall have an automated system, available twenty-four (24)-hours a day, seven (7) days a week. This automated system shall include the capability of providing callers with operating instructions on what to do in case of an emergency and the option to talk directly to a nurse or other clinician or leave a message, including instructions on how to leave a message and when that message will be returned. The Contractor shall ensure that the voice mailbox has adequate capacity to receive all messages and that member services staff return all calls by close of business the following business day.

2.13.10.4 The toll-free phone line shall be accessible by all enrollees, regardless of whether they are calling about physical health or behavioral health. The Contractor may either route the call to another entity or conduct a "warm transfer" to another entity, but the Contractor shall not require an enrollee to call a separate number regarding behavioral health services.

2.13.10.5 If the Contractor's nurse triage/nurse advice line is separate from its enrollee services line, the number for the nurse triage/nurse advice line shall be the same for all enrollees, regardless of whether they are calling about physical health or behavioral health services, and the Contractor may either route calls to another entity or conduct "warm transfers," but the Contractor shall not require an enrollee to call a separate number.

2.13.10.6 The Contractor shall have sufficient telephone lines to answer incoming calls. The Contractor shall ensure sufficient staffing to meet performance standards listed in this Contract. LDH reserves the right to specify staffing ratio and/or other requirements, if performance standards are not met or it is determined that the call center staffing and/or processes are not sufficient to meet enrollee needs as determined by LDH.

2.13.10.7 The Contractor shall develop a contingency plan for hiring call center staff to address overflow calls and emails and to maintain call center access standards set forth for MCO performance. The Contractor shall develop and implement a plan to sustain call center performance levels in situations where there is high call and/or e-mail volume

or low staff availability. Such situations may include, but are not limited to, increases in call volume, emergency situations (including natural disasters such as hurricanes), staff in training, staff illnesses, and vacations.

2.13.10.8 The Contractor shall develop telephone help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards and emergencies including but not limited to hurricane-related evacuations. The Contractor shall submit these telephone help line policies and procedures, including performance standards, to LDH for written approval at least thirty (30) calendar days prior to implementation of any policies. This shall include a capability to track and report information on each call. The MCO call center shall 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.

2.13.10.9 The Contractor 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 Contractor shall submit call center quality criteria and protocols to LDH for review and approval annually.

2.13.10.10 The Contractor shall provide general assistance and information to individuals and their families seeking to understand how to access care. For CSoC eligible enrollees, the Contractor shall provide information to families about the specialized services and how to contact the CSoC contractor.

2.13.11 24-Hour Behavioral Health Crisis Line

2.13.11.1 The Contractor shall maintain a twenty-four (24)-hour toll-free crisis response center to respond to specialized behavioral health needs. The call center may be combined with the Contractor's twenty-four (24)-hour nurse line or may be a separate line, but must provide the following:

2.13.11.1.1 Twenty-four (24)-hour, seven (7)-day a week access to staff;

2.13.11.1.2 Answered by a live voice at all times; and

2.13.11.1.3 Have sufficient telephone lines to answer incoming calls.

2.13.11.2 The Contractor shall assist and triage callers who may be in crisis by effectuating an immediate transfer to a case manager. The call shall be answered within thirty (30) seconds and only transferred via a warm line to a LMHP. The Contractor shall respect the caller's privacy during all communications and calls.

2.13.12 Automated Call Distribution (ACD) System

The Contractor shall install, operate, and monitor a system for the customer service telephone call center. The system shall:

2.13.12.1 Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;

2.13.12.2 Transfer calls to other telephone lines;

2.13.12.3 Provide detailed analysis as required for the reporting requirements, as specified, including the quantity, length and types of calls received; elapsed time before the calls are answered; the number of calls transferred or referred; abandonment rate; wait time; busy rate; response time; and call volume;

2.13.12.4 Provide a message that notifies callers that the call may be monitored for quality control purposes;

2.13.12.5 Measure the number of calls in the queue;

2.13.12.6 Measure the length of time callers are on hold;

2.13.12.7 Measure the total number of calls and average calls handled per day/week/month;

2.13.12.8 Measure the average hours of use per day;

2.13.12.9 Assess the busiest times and days by number of calls;

2.13.12.10 Record calls to assess whether answered accurately;

2.13.12.11 Provide a backup telephone system that shall operate in the event of line trouble, emergency situations including natural disasters, or other problems so that access to the telephone lines is not disrupted;

2.13.12.12 Provide interactive voice response (IVR) options that are user-friendly to enrollees and include a decision tree illustrating IVR system; and

2.13.12.13 Inform the enrollee to dial 911 if there is an emergency.

2.13.13 Call Center Performance Standards

2.13.13.1 The Contractor shall comply with the following requirements:

2.13.13.1.1 Answer ninety-five percent (95%) of calls within thirty (30) seconds or direct the call to an automatic call pickup system with IVR options;

2.13.13.1.2 No more than one percent (1%) of incoming calls receive a busy signal;

2.13.13.1.3 Maintain a hold time of three (3) minutes or less. Hold time, or wait time, for the purposes of this Contract includes 1) the time a caller spends waiting for a customer service representative to assist them after the caller has navigated the IVR system and requested a live person; and 2) the measure of time when a customer service representative places a caller on hold; and

2.13.13.1.4 Maintain abandoned rate of calls of not more than five percent (5%).

2.13.13.2 The Contractor shall conduct ongoing quality assurance to ensure these standards are met.

2.13.13.3 If LDH determines that it is necessary to conduct onsite monitoring of the Contractor's member call center functions, the Contractor is responsible for all reasonable costs incurred by LDH or its authorized agent(s) relating to such monitoring.

2.13.14 Interpretation and Written Translation Services

2.13.14.1 In accordance with 42 C.F.R. §438.10(d) LDH shall provide on its website the prevalent non-English languages spoken by enrollees in the State.

2.13.14.2 The Contractor shall make interpretation services, including real-time oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language (ASL), available free of charge to each potential enrollee and enrollee. This applies to all non-English languages and not just those that Louisiana specifically requires (Spanish). These interpretation services shall be made available to network providers treating non-English speaking enrollees at no charge. The Contractor may coordinate with OPH/Louisiana Commission for the Deaf for American Sign Language interpretation services.

2.13.14.3 The Contractor shall notify its enrollees that interpretation is available for any language and how to access those services. On materials where this information is provided, the notation shall be written in Spanish. Embedded videos in American Sign Language shall be made available on the MCO website with pertinent information labeled for enrollees that are deaf, deaf-blind, or hard of hearing.

2.13.14.4 The Contractor shall ensure that translation services are provided for all written marketing and enrollee materials for any language that is spoken as a primary language for four percent (4%) or more enrollees, or potential enrollees of an MCO. Within ninety (90) calendar days of notice from LDH, materials shall be translated and made available. Materials shall be made available at no charge in that specific language to ensure a reasonable chance for all enrollees to understand how to access the MCO and use services appropriately as specified in 42 C.F.R. §438.10(c)(4) and (5).

2.13.14.5 Written materials shall also be made available in alternative formats upon request of the enrollee or potential enrollee at no cost. Auxiliary aids and services shall also be made available upon request of the potential enrollee or enrollee at no cost. Written materials shall include taglines in the prevalent non-English languages in the state, as well as large print, and Braille explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the MCO's enrollee/customer service unit. Large print means printed in a font size no smaller than eighteen (18) point.

2.14 Marketing and Education

2.14.1 Marketing and Enrollee Education, General Guidelines

2.14.1.1 Marketing, for purposes of this Contract, is defined in 42 C.F.R. §438.104(a) as any communication from an MCO to a Medicaid beneficiary who is not enrolled in that MCO that can reasonably be interpreted to influence the beneficiary to: 1) enroll in that MCO, or 2) either not enroll in, or disenroll from, another MCO.

2.14.1.2 Marketing differs from enrollee education, which is defined as communication with an **enrolled** member of an MCO for the purpose of retaining the member as an enrollee, and improving the health status of enrolled members.

2.14.1.3 Marketing and enrollee education includes both verbal presentations and written materials.

2.14.1.4 Marketing materials are produced in any medium and include, but are not limited to, the concepts of advertising, public service announcements, printed publications, websites, social media, mobile device applications, broadcasts and electronic messages designed to increase awareness and interest in the MCO. This includes any information that can reasonably be interpreted as intended to market the MCO to potential enrollees.

2.14.1.5 Enrollee materials generally include, but are not limited to, member handbooks, identification cards, provider directories, health education materials, form letters, mass mailings, e-mails, SMS messages, member letters, and newsletters.

2.14.1.6 All marketing and enrollee education guidelines are applicable to the MCO, its agents, material subcontractors, volunteers, and/or providers.

2.14.1.7 All marketing and enrollee education activities shall be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of beneficiaries or the general community.

2.14.1.8 The Contractor shall provide information to enrollees and potential enrollees in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees [42 C.F.R. §438.10(c)(1)]. All marketing and enrollee materials and activities shall comply with the information requirements in 42 C.F.R. §438.10 and the LDH requirements set forth in this Contract and the **MCO Manual**.

2.14.1.9 The Contractor shall make its written materials that are critical to obtaining services, including provider directories, member handbooks, appeal and grievance notices, and denial and termination notices available in the prevalent non-English languages in the State as required by LDH [42 C.F.R. §438.10(d)(3)]. The Contractor is responsible for creation, production and distribution of its own marketing and enrollee materials to its enrollees.

2.14.1.10 The Contractor shall not perform any direct marketing to potential enrollees in accordance with 42 U.S.C. §1396u-2(d)(2) and 42 C.F.R. §438.104.

2.14.1.11 Activities involving distribution and completion of an MCO enrollment form during the course of enrollment activities is an enrollment function and is the sole responsibility of LDH's enrollment broker.

2.14.1.12 The Contractor shall ensure that marketing and enrollee materials are accurate and do not mislead, confuse, or defraud the enrollee/potential enrollee or LDH as required by 42 U.S.C. §1396u-2(d)(2) and 42 C.F.R. §438.104.

2.14.1.13 The Contractor shall comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care, as outlined by the Department of Health and Human Services' Office of Minority Health, incorporating the standards found here: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53. Additionally, the Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees.

2.14.1.14 The Contractor shall develop marketing and enrollee materials that appropriately address all the MCO populations outlined in the *Eligibility and Enrollment* section of the Contract.

2.14.1.15 Sponsorships and events shall be scheduled throughout the state in a geographically equitably manner.

2.14.2 Prohibited Marketing Activities

The Contractor and its subcontractors are prohibited from engaging in the following activities:

2.14.2.1 Marketing directly to Medicaid beneficiaries or MCO potential enrollees, including persons currently enrolled in Medicaid or other MCOs (including direct mail advertising, "spam", door-to-door, telephonic, or other "cold call" marketing techniques);

2.14.2.2 Asserting that the MCO is endorsed by CMS, the federal or state government or similar entity;

2.14.2.3 Distributing plans and materials or making any statement (written or verbal) that LDH determines to be inaccurate, false, confusing, misleading or intended to defraud enrollees or LDH. This includes statements which mislead or falsely describe covered services, membership or availability of providers and qualifications and skills of providers, and assertions the recipient of the communication must enroll in a specific plan in order to obtain or not lose benefits;

2.14.2.4 Portraying competitors or potential competitors in a negative manner;

2.14.2.5 Attaching a Medicaid application and/or enrollment form to marketing materials to any enrollee not currently enrolled with the MCO;

2.14.2.6 Assisting with enrollment or disenrollment or improperly influencing MCO selection;

2.14.2.7 Using the seal of the state of Louisiana, LDH's name, logo or other identifying marks on any materials produced or issued, without the prior written consent of LDH;

2.14.2.8 Distributing marketing information (written or verbal) that implies that joining MCOs or a particular MCO is the only means of preserving Medicaid coverage or that MCOs or a particular MCO is the only provider of Medicaid services and the potential enrollee must enroll in the MCO or MCOs to obtain benefits or not lose benefits;

2.14.2.9 Comparing its MCO to another organization / MCO by name;

2.14.2.10 Sponsoring or attending any marketing or community health activities or events without notifying LDH within the timeframes specified in this Contract;

2.14.2.11 Engaging in any marketing activities, including unsolicited personal contact with a potential enrollee, at an employer-sponsored enrollment event where employee participation is mandated by the employer;

2.14.2.12 Marketing or distributing marketing materials, including member handbooks, and soliciting enrollees in any other manner, inside, at the entrance or within one hundred (100) feet of check cashing establishments, public assistance offices, DCFS eligibility offices for the Supplemental Nutrition Assistance Program (SNAP), FITAP, Health Units, Medicaid Eligibility Offices, and/or certified Medicaid Application Centers without prior approval from LDH;

2.14.2.13 Conducting marketing or distributing marketing materials in hospital EDs, including the ED waiting areas, patient rooms or treatment areas;

2.14.2.14 Purchasing or otherwise acquiring or using mailing lists of Medicaid beneficiaries from third party vendors, including providers and state offices;

2.14.2.15 Using raffle tickets or event attendance or sign-in sheets to develop mailing lists of potential enrollees;

2.14.2.16 Charging enrollees for goods or services distributed at events;

2.14.2.17 Charging enrollees a fee for accessing the MCO website;

2.14.2.18 Influencing enrollment in conjunction with the sale or offering of any private insurance or Medicare Advantage Plan;

2.14.2.19 Using terms that would influence, mislead or cause potential enrollees to contact the MCO, rather than the LDH-designated enrollment broker, for enrollment;

2.14.2.20 Referencing the commercial component of the MCO in any of its Medicaid MCO enrollee marketing materials, if applicable; and

2.14.2.21 Using terms in marketing materials such as “choose,” “pick,” “join,” etc. unless the marketing materials include the enrollment broker’s contact and mobile application information.

2.14.3 Allowable Marketing Activities

2.14.3.1 The Contractor and its subcontractors shall be permitted to perform the following activities:

2.14.3.1.1 Distribute general information through mass media (i.e. newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, billboards and other media outlets) in keeping with prohibitions to placement as detailed in this Contract;

2.14.3.1.2 Make telephone calls and home visits only to enrollees currently enrolled in the MCO (enrollee education and outreach) for the purpose of educating them about services offered by or available through the MCO;

2.14.3.1.3 Respond to verbal or written requests for information made by potential enrollees, in keeping with the response plan outlined in the marketing plan approved by LDH prior to response;

2.14.3.1.4 Provide promotional giveaways that exceed $15.00 value to current enrollees only;

2.14.3.1.5 Attend or organize activities that benefit the entire community such as health fairs or other health education and promotion activities. Notification to LDH must be made of the activity and details must be provided about the planned marketing activities;

2.14.3.1.6 Attend activities at a business at the invitation of the entity. Notification to LDH shall be made of the activity and details shall be provided about the planned marketing activities;

2.14.3.1.7 Conduct telephone marketing only during incoming calls from potential enrollees. The Contractor may return telephone calls to potential enrollees only when requested to do so by the caller. The Contractor shall utilize the response plan outlined in the marketing plan, approved by LDH, during these calls; and

2.14.3.1.8 Send plan-specific materials to potential enrollees at the potential enrollee's request.

2.14.3.2 In any instance where an MCO-allowable activity conflicts with a prohibited activity, the prohibited activity guidance shall prevail.

2.14.4 Marketing and Enrollee Materials Approval Process

2.14.4.1 The Contractor shall obtain prior written approval from LDH for all marketing and enrollee materials for potential or current enrollees. This includes, but is not limited to, print, television, web, and radio advertisements; member handbooks, identification cards and provider directories; call scripts for outbound calls or customer service centers; MCO website screen shots; promotional items; brochures; letters and mass mailings and e-mailings. Neither the Contractor nor its

subcontractors may distribute any MCO marketing or enrollee materials without prior LDH consent.

2.14.4.2 All proposed materials shall be submitted via email to LDH in a format and manner approved by LDH.

2.14.4.2.1 Materials submitted as part of the original marketing and enrollee education plan shall be considered approved with the approval of the plan if the materials were in final draft form.

2.14.4.3 The Contractor shall obtain prior written approval for all materials developed by a recognized entity that is not associated with the Contractor, such as a government entity or a nonprofit organization, that the Contractor wishes to distribute. LDH shall only consider materials when submitted by the Contractor (not subcontractors).

2.14.4.4 Review Process for Materials

2.14.4.4.1 LDH shall review the submitted marketing and enrollee materials and either approve, deny or submit changes within thirty (30) calendar days from the date of submission.

2.14.4.4.2 Once enrollee materials are approved in writing by LDH, the Contractor shall submit an electronic version of the final printed product within ten (10) calendar days from the print date, unless otherwise specified by LDH. If LDH requests that original prints be submitted in hard copy, photo copies may not be submitted for the final product. Upon request, the Contractor shall provide additional original prints of the final product to LDH.

2.14.4.4.3 Prior to modifying any approved enrollee material, the Contractor shall submit for written approval by LDH, a detailed description of the proposed modification accompanied by a draft of the proposed modification.

2.14.4.4.4 LDH reserves the right to require the Contractor to discontinue or modify any marketing or enrollee materials after approval.

2.14.4.4.5 MCO materials used for the purpose of marketing and enrollee education, except for the original MCO marketing and enrollee education plan, are deemed approved if a response from LDH is not returned within thirty (30) calendar days following receipt of materials by LDH.

2.14.4.4.6 The Contractor shall review all marketing and enrollee materials on an annual basis and revise materials, if necessary, to reflect current practices. Any revisions shall be approved by LDH prior to distribution.

2.14.5 Events and Activities Approval Process

2.14.5.1 The Contractor shall provide written notice to LDH in accordance with the **MCO Manual** for all marketing and enrollee education events and activities for potential or current enrollees as well as any community/health education activities that are

focused on health care benefits (health fairs or other health education and promotion activities).

2.14.5.2 The Contractor shall obtain prior written approval from LDH for any press or media events or activities or activities that include sponsorship.

2.14.5.2.1 Activities and events submitted as part of the original marketing and enrollee education plan shall be considered approved with the approval of the plan if the activity or event details are complete.

2.14.5.3 Review Process for Events and Activities

2.14.5.3.1 LDH shall review proposed sponsorship, press, or media events and activities and either approve or deny within seven (7) calendar days from the date of submission.

2.14.5.3.2 In the case where a sponsorship, press, or media event or activity arises and approval within the seven (7) calendar day timeframe is not possible due to the proximity of the event or activity, the Contractor may request an expedited approval. LDH reserves the right to deny such requests.

2.14.5.3.3 Proposed sponsorship, press, or media events and activities, except for those included in the original MCO marketing and enrollee education plan, are deemed approved if a response from LDH is not returned within seven (7) calendar days following notice of event to LDH.

2.14.5.3.4 Any revisions to approved sponsorship, press, or media events and activities must be resubmitted for approval by LDH prior to the event or activity in accordance with the **MCO Manual**.

2.14.5.3.5 LDH reserves the right to require the Contractor to discontinue or modify any marketing or enrollee education events after approval.

2.14.6 MCO Provider Marketing Guidelines

2.14.6.1 When conducting any form of marketing in a provider's office, the Contractor shall acquire and keep on file the written consent of the provider.

2.14.6.2 The Contractor shall not require its providers to distribute MCO-prepared marketing communications to their patients.

2.14.6.3 The Contractor shall not provide incentives or giveaways to providers to distribute marketing communications to enrollees or potential enrollees.

2.14.6.4 The Contractor shall not conduct enrollee education or distribute enrollee education materials in provider offices.

2.14.6.5 The Contractor shall not allow providers to solicit enrollment or disenrollment in an MCO, or distribute MCO-specific materials as a marketing activity.

2.14.6.6 The Contractor shall not provide printed materials with instructions detailing how to change MCOs to enrollees of other MCOs to providers.

2.14.6.7 The Contractor shall instruct participating providers regarding the following communication requirements:

2.14.6.7.1 Participating providers who wish to let their patients know of their affiliations with one (1) or more MCOs shall list each MCO with whom they have contracts;

2.14.6.7.2 Participating providers may display and/or distribute health education materials for **all** contracted MCOs or they may choose not to display and/or distribute for **any** contracted MCOs. Health education materials shall adhere to the following guidance:

2.14.6.7.2.1 Health education posters cannot be larger than 16” x 24”;

2.14.6.7.2.2 Children’s books, donated by MCOs, must be in common areas;

2.14.6.7.2.3 Materials may include the MCO’s name, logo, phone number and website; and

2.14.6.7.2.4 Providers are not required to distribute and/or display all health education materials provided by each MCO with whom they contract. Providers can choose which items to display as long as they distribute items from each contracted MCO and that the distribution and quantity of items displayed are equitable;

2.14.6.7.3 Providers may display marketing materials for MCOs provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all MCOs with whom the provider has a contract;

2.14.6.7.4 Providers may display MCO participation stickers, but they shall display stickers by **all** contracted MCOs or choose to not display stickers for **any** contracted MCOs;

2.14.6.7.5 MCO stickers indicating the provider participates with a particular MCO cannot be larger than 5" x 7” and may not include anything more than the MCO name and/or logo or with the statement that it is accepted or welcomed here;

2.14.6.7.6 Providers may inform their patients of the benefits, services and specialty care services offered through the MCOs in which they participate. However, providers shall not recommend one MCO over another MCO, offer patients incentives for selecting one MCO over another, assist the patient in deciding to select a specific MCO in any way, or otherwise intend to influence a enrollee’s decision;

2.14.6.7.7 Upon actual termination of a contract with the MCO, a provider that has contracts with other MCOs may notify their patients of the change in status and the impact of such a change on the patient including the date of the contract termination. Providers shall continue to see current patients enrolled in the MCO until the contract is terminated according to all terms and conditions specified in the contract between the provider and the MCO; and

2.14.6.7.8 The MCO shall not produce branded materials instructing enrollees on how to change a MCO. They must use LDH provided or approved materials and shall refer enrollees directly to the enrollment broker for needed assistance.

2.14.7 MCO Marketing Representative Guidelines

2.14.7.1 All MCO marketing representatives, including subcontractors assigned to marketing, shall successfully complete a training program about the basic concepts of Louisiana Medicaid, Medicaid Managed Care and the enrollees' rights and responsibilities relating to enrollment in MCOs and grievance and appeals rights before engaging in direct marketing to potential enrollees.

2.14.7.2 The Contractor shall ensure that all marketing representatives engage in professional and courteous behavior. The Contractor shall not participate, encourage, or accept inappropriate behavior by its marketing representatives, including but not limited to interference with other MCO presentations or talking negatively about other MCOs.

2.14.7.3 The Contractor shall not offer compensation to a marketing representative, including salary increases or bonuses, based solely on an overall increase in MCO enrollment. Compensation may be based on periodic performance evaluations which consider enrollment productivity as one (1) of several performance factors.

2.14.7.4 Sign-on bonuses for marketing representatives are prohibited.

2.14.8 Written Materials Guidelines

The Contractor shall comply with the following requirements as it relates to all written enrollee materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.). The Contractor shall also comply with the requirements outlined in 42 C.F.R. §438.10, 42 U.S.C. §1396u-2(d)(2)(A)(i), and 42 U.S.C. §1396u-2(a)(5):

2.14.8.1 All enrollee materials shall be in a style and reading level that shall accommodate the reading skills of MCO enrollees. In general, the writing shall be at no higher than a 6.9 grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to ensure accuracy:

- Flesch – Kincaid;
- Fry Readability Index;

- PROSE The Readability Analyst (software developed by Educational Activities, Inc.);
- Gunning FOG Index;
- McLaughlin SMOG Index; or
- Other computer generated readability indices accepted by LDH.

2.14.8.2 All written materials shall be clearly legible with a minimum font size of twelve (12)-point, with the exception of member ID cards, and or otherwise approved by LDH.

2.14.8.3 LDH reserves the right to require evidence that written materials for enrollees have been tested against the 6.9 grade reading-level standard.

2.14.8.4 If a person making a testimonial or endorsement for an MCO has a financial interest in the company, such fact shall be disclosed in the marketing materials.

2.14.8.5 The quality of materials used for printed materials shall be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans if applicable.

2.14.8.6 The MCO's name, mailing address (and physical location, if different), website and toll-free number shall be prominently displayed on at least one (1) page within all multi-paged marketing materials.

2.14.8.7 All multi-page written enrollee materials shall notify the enrollee that real-time oral and American Sign Language interpretation is available for any language at no expense to them and provide information on how to access those services;

2.14.8.8 All written materials related to MCO and PCP enrollment shall advise potential enrollees to verify with the medical services providers they prefer or have an existing relationship with, that such medical services providers are participating providers of the selected MCO and are available to serve the enrollee.

2.14.8.9 Alternative forms of communication shall be provided upon request for persons with visual, hearing, speech, physical or developmental disabilities. These alternatives shall be provided at no expense to the enrollee.

2.14.8.10 Marketing materials shall be made available through the MCO's entire service area. Materials may be customized for specific parishes and populations within the MCO's service area.

2.14.8.11 All marketing activities shall provide for equitable distribution of materials without bias toward or against any group.

2.14.8.12 Marketing materials shall accurately reflect general information, which is applicable to the average potential enrollee of the MCO.

2.14.8.13 The MCO shall include in all enrollee materials the following:

2.14.8.13.1 The date of issue;

2.14.8.13.2 The date of revision; and/or

2.14.8.13.3 If the prior versions are obsolete.

2.14.8.14 Except as indicated, the MCOs may develop their own materials that adhere to requirements set forth in this document or use State developed model enrollee notices. State developed model notices must be used for denial notices and pharmacy lock-in notices.

2.14.9 MCO Website Guidelines

2.14.9.1 The MCO website, available in English and Spanish, shall include an enrollee-focused section which can be a designated section of the Contractor's general informational website, which is interactive and accessible using mobile devices, and has the capability for bidirectional communications, i.e. enrollees can submit questions and comments to the Contractor and receive responses.

2.14.9.2 The MCO website shall include general and up-to-date information about its MCO as it relates to the Louisiana Medicaid program. This may be developed on a page within its existing website to meet these requirements.

2.14.9.3 The Contractor shall obtain prior written approval from LDH before updating the enrollee-facing portion of its website.

2.14.9.4 The Contractor shall remain compliant with HIPAA privacy and security requirements when providing enrollee eligibility or enrollee identification information on the website.

2.14.9.5 The MCO website shall, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act (ADA), and meet all standards the ADA sets for people with visual impairments and disabilities that make usability a concern. The MCO website shall follow all written marketing guidelines included in this Section.

2.14.9.6 Use of proprietary items that would require a specific browser is not allowed.

2.14.9.7 The website shall be, at a minimum, functionally equivalent to the website maintained by the LDH FI.

2.14.9.8 The Contractor shall provide the following information on its website, and such information shall be easy to find, navigate, and understand by all enrollees:

2.14.9.8.1 The most recent version of the Member Handbook;

2.14.9.8.2 Telephone contact information, including a toll-free customer service number prominently displayed and a Telecommunications Device for the Deaf (TDD) number;

2.14.9.8.3 A searchable list of network providers with a designation of open versus closed panels, which shall be updated in real time and upon changes to the network;

2.14.9.8.4 The link to the enrollment broker's website, mobile application, and toll-free number for questions about enrollment and disenrollment;

2.14.9.8.5 The link to the State Medicaid website and the toll-free number for questions about Medicaid eligibility;

2.14.9.8.6 A section for the Contractor's providers that includes contact information, claims submittal information, prior authorization instructions, and a toll-free telephone number;

2.14.9.8.7 General customer service information;

2.14.9.8.8 Updates on emergency situations that may impact the public, such as natural and man-made disasters that would require time sensitive action by enrollees, such as evacuation from their homes or communities or other preparedness-related activities. The website shall include hyperlinks to state and federal emergency preparedness websites;

2.14.9.8.9 Information on how to file grievances and appeals; and

2.14.9.8.10 Information specific to access for specialized behavioral health services, including but not limited to:

2.14.9.8.10.1 The link to the LDH-OBH and CSoC websites;

2.14.9.8.10.2 Information on how to access specialized behavioral health services;

2.14.9.8.10.3 Crisis response information and toll-free crisis telephone numbers;

2.14.9.8.10.4 Information regarding community forums, volunteer activities, and workgroups/committees that provide opportunities for enrollees receiving services, their families/caregivers, providers, and stakeholders to become involved; and

2.14.9.8.10.5 Information regarding advocacy organizations, including how enrollees and other families/caregivers may access advocacy services.

2.14.10 Web and Mobile-Based Enrollee Applications

2.14.10.1 No later than the operational start date, the Contractor shall provide a web or mobile based enrollee/patient portal that includes the following information and features:

2.14.10.1.1 Medical claims information such as lab and imaging results, medications and key health appointments;

2.14.10.1.2 Social services information and resources, such as housing supports, food programs, etc.;

2.14.10.1.3 The capability for additional health information to be entered by the enrollee;

2.14.10.1.4 Consumer-friendly content that complies with MCO enrollee education guidelines; and

2.14.10.1.5 Tools to help higher risk users access State-based or plan-based resources such as smoking cessation or weight management programs. Need will be determined by the MCO health-risk assessment or other tools used for establishing higher risk users.

2.14.10.2 The Contractor shall provide reporting and analytics to help the State measure the effectiveness of such applications.

2.14.11 Marketing Reporting and Monitoring

2.14.11.1 The Contractor shall submit an updated plan of all marketing and enrollee education efforts for the coming year to LDH in accordance with the **MCO Manual**.

2.14.11.2 To ensure the fair and consistent investigation of alleged violations, LDH has outlined the following reporting guidelines:

2.14.11.2.1 Alleged marketing violations shall be reported to LDH in accordance with the **MCO Manual**.

2.14.11.2.2 Upon written receipt of allegations, LDH shall:

2.14.11.2.2.1 Acknowledge receipt, in writing, within five (5) business days from the date of receipt of the allegation.

2.14.11.2.2.2 Begin investigation within five (5) business days from receipt of the allegation and complete the investigation within thirty (30) calendar days. LDH may extend the time for investigation if there are extenuating circumstances;

2.14.11.2.2.3 Analyze the findings and take appropriate action (see *Contract Non-Compliance* section, for additional details); and

2.14.11.2.2.4 Notify the complainant after appropriate action has been taken.

2.14.11.3 LDH may impose sanctions against the Contractor for marketing and enrollee education violations as outlined in the *Contract Non-Compliance* section of this Contract.

2.14.12 Pharmacy-Related Marketing and Enrollee Education

2.14.12.1 The Contractor, its subcontractors, including PBMs, and network providers, are subject to the Marketing and Member Education requirements set forth in this section. This includes the review and approval of all marketing and member materials including, but not limited to, websites and social media, ID cards, call scripts for outbound calls or customer service centers, provider directories, advertisement and direct member mailings.

2.14.12.2 Members of an MCO shall have free access to any pharmacy participating in the MCO's network (except in cases where the enrollee is participating in the pharmacy/prescriber lock-in program). Neither the Contractor nor any subcontractor is allowed to steer enrollees to certain network providers including specialty pharmacies. LDH retains the discretion to deny the use of marketing and enrollee material that it deems to promote undue patient steering.

2.14.12.3 The MCO is prohibited from displaying the names and/or logos of co-branded PBMs on the MCO's member identification card. The MCO that chooses to co-brand with providers must include on marketing materials (other than ID cards) the following language: "Other Pharmacies are Available in Our Network."

2.14.12.4 Co-branded marketing materials shall be submitted to LDH by the MCO for approval prior to distribution, in accordance with the processes and timelines outlined in this section.

2.14.13 Marketing and Education Violations

2.14.13.1 Whenever LDH determines that the Contractor or any of its agents, subcontractors, volunteers or providers has engaged in any unfair, deceptive, or prohibited marketing or enrollee education practices in connection with proposing, offering, selling, soliciting, and providing any health care services, one or more of the remedial actions as specified in this Section shall apply.

2.14.13.2 Unfair, deceptive, or prohibited marketing practices shall include, but are not limited to:

2.14.13.2.1 Failure to secure written approval before distributing marketing or enrollee materials;

2.14.13.2.2 Failure to secure written approval for events involving sponsorships and media events;

2.14.13.2.3 Engaging in, encouraging, or facilitating prohibited marketing by a provider;

2.14.13.2.4 Directly marketing to enrollees of another MCO or potential enrollees;

2.14.13.2.5 Failure to meet time requirements for communication with new enrollees (distribution of welcome packets, welcome calls);

2.14.13.2.6 Failure to provide interpretation services or make materials available in required languages;

2.14.13.2.7 Engaging in any of the prohibited marketing and enrollee education practices detailed in this Contract;

2.14.13.2.8 False, misleading oral or written statement, visual description, advertisement, or other representation of any kind which has the capacity, tendency, or effect of deceiving or misleading potential enrollees or enrollees with respect to any health care services, MCO, or health care provider; or the Louisiana Medicaid managed care program;

2.14.13.2.9 Representation that an MCO or network provider offers any service, benefit, access to care, or choice which it does not have;

2.14.13.2.10 Representation that an MCO or health care provider has any status, certification, qualification, sponsorship, affiliation, or licensure which it does not have;

2.14.13.2.11 Failure to state a material fact if the failure deceives or tends to deceive;

2.14.13.2.12 Offering any kickback, bribe, award, or benefit to any Medicaid beneficiary as an inducement to select, or to refrain from selecting any health care service, MCO, or health care provider, unless the benefit offered is medically necessary health care or is among the value added benefits that are offered to all enrollees or predefined eligibility groups; and

2.14.13.2.13 Use of the Medicaid beneficiary's or another person's information which is confidential, privileged, or which cannot be disclosed to or obtained by the user without violating a state or federal confidentiality law, including:

2.14.13.2.13.1 Medical records information;

2.14.13.2.13.2 Information which identifies the enrollee or any enrollee of his or her household as a beneficiary of any government sponsored or mandated health coverage program; and

2.14.13.2.13.3 Use of any device or artifice in advertising an MCO or soliciting a Medicaid beneficiary which misrepresents the solicitor's profession, status, affiliation, or mission.

2.14.13.3 The MCO shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.

2.14.13.4 If LDH determines the Contractor or its subcontractors has steered potential enrollees to join the MCO, LDH may impose one or more of the following non-compliance actions:

2.14.13.4.1 The enrollee(s) shall be disenrolled from the MCO at the earliest effective date allowed;

2.14.13.4.2 PMPMs for the months(s) the enrollee(s) was enrolled in the MCO will be recouped;

2.14.13.4.3 The Contractor shall be assessed an additional monetary penalty per enrollee (see Attachment E, *Table of Monetary Penalties*); or

2.14.13.4.4 The Contractor shall submit a letter to each enrollee notifying the enrollee of the imposed sanction and of their right to choose another MCO.

2.14.13.5 If LDH determines the Contractor has violated any of the marketing or education activities outlined in the Contract, the Contractor may be subject to remedial actions specified in this Section and/or a monetary penalty per violation/incident (see Attachment E, *Table of Monetary Penalties*). The amount and type of penalty shall be at the sole discretion of LDH.

2.14.14 Remedial Actions for Marketing Violations

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

2.14.14.2 LDH may require the Contractor to recall previously authorized marketing material(s).

2.14.14.3 LDH may suspend enrollment of new enrollees to the Contractor for an amount of time specified by LDH.

2.14.14.4 LDH may require the Contractor to contact each enrollee who enrolled during the period while the Contractor was out of compliance, in order to explain the nature of the non-compliance and inform the enrollee of his or her right to transfer to another MCO.

2.14.14.5 LDH may prohibit future marketing activities by the Contractor for an amount of time specified by LDH.

2.15 Enrollee Grievances, Appeals, and State Fair Hearings

2.15.1 General Provisions

2.15.1.1 The Contractor shall establish and maintain a system for receiving, reviewing and resolving enrollee grievances and appeals. Components shall include a grievance process, an appeal process, and a process to access a state fair hearing.

2.15.1.2 The Contractor 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 Contractor, and shall be provided upon request of the enrollee. The Contractor shall make all forms easily available on the Contractor's website.

2.15.1.3 The Contractor shall ensure that all decisions on grievances and appeals are made by health care professionals in accordance with federal regulations.

2.15.1.4 The Contractor shall refer all enrollees who are dissatisfied with the Contractor or its activities to the Contractor grievance system.

2.15.1.5 The Contractor shall assist the enrollee in completing forms and following the procedures for filing a grievance or appeal, or requesting a state fair hearing.

2.15.1.6 Upon request, the Contractor 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 Contractor 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 Contractor shall provide such records free of charge and within seven (7) calendar days of request.

2.15.1.7 The Contractor shall maintain a complete and accurate record of all grievances and appeals for ten (10) years. The Contractor shall maintain and make grievance and appeal records available upon request by LDH and CMS. The record of each grievance and appeal shall contain, at a minimum, the information specified in 42 C.F.R. §438.416(b).

2.15.1.8 The Contractor shall log, track and trend all grievances, regardless of the degree of seriousness or whether the enrollee expressly requests filing the concern.

2.15.1.9 The Contractor shall report on grievances and appeals to LDH in a manner and format determined by LDH.

2.15.1.10 The Contractor shall 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.

2.15.1.11 A provider may file an appeal or request a state fair hearing on behalf of the enrollee with the enrollee's written consent.

2.15.2 Process for Grievances

2.15.2.1 An enrollee, or authorized representative acting on the enrollee's behalf, may file a grievance orally or in writing at any time.

2.15.2.2 The Contractor's process for handling enrollee grievances shall include acknowledgement in writing within five (5) business days of receipt of each grievance.

2.15.2.3 The Contractor 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 Contractor receives the grievance.

2.15.2.4 The Contractor shall extend the timeframe of disposition for a grievance by up to fourteen (14) calendar days if:

2.15.2.4.1 The enrollee requests the extension; or

2.15.2.4.2 The Contractor 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.

2.15.2.5 If the timeframe is extended other than at the enrollee's request, the Contractor 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.

2.15.3 Standard Resolution of Appeals

2.15.3.1 The Contractor shall adhere to the following timeframes for processing appeals:

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

2.15.3.1.2 Once an oral appeal is received:

2.15.3.1.2.1 The Contractor shall notify the enrollee verbally that a written confirmation is required for the appeal process to continue. The Contractor shall inform the enrollee they shall receive a notice or written confirmation of the appeal.

2.15.3.1.2.2 The Contractor shall send a notice to the enrollee, acknowledging the oral appeal request was received and written confirmation is required. This notice shall contain the timeframe for receipt of the written confirmation and future actions. A written confirmation shall not be required if the enrollee requests an expedited resolution.

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

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

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

- The Contractor shall close the appeal as incomplete for non-receipt of written confirmation.
- The Contractor shall send a notification to the enrollee of the appeal

closure. This notice shall 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) calendar days of the adverse action. This closure does not escalate the appeal to a state fair hearing since the initial appeal process was not completed.

2.15.3.1.2.6 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) calendar days of the adverse action.

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

2.15.3.1.4 The Contractor shall provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

2.15.3.1.5 The Contractor shall include, as parties to the appeal:

2.15.3.1.5.1 The enrollee, the enrollee’s authorized representative, and/or the enrollee’s legal representative; or

2.15.3.1.5.2 The legal representative of a deceased enrollee's estate.

2.15.3.2 The date of the oral filing shall constitute date of receipt.

2.15.3.3 The Contractor shall acknowledge each appeal in writing within five (5) business days of receipt of each appeal unless the enrollee requests an expedited resolution.

2.15.3.4 The Contractor shall continue to provide benefits and services during the appeal if all of the following occur:

2.15.3.4.1 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:

2.15.3.4.1.1 Within ten (10) calendar days of the Contractor mailing the notice of adverse benefit determination; or

2.15.3.4.1.2 The intended effective date of the Contractor's proposed action.

2.15.3.4.2 The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

2.15.3.4.3 The services were ordered by an authorized provider;

2.15.3.4.4 The original period covered by the original authorization has not expired; and

2.15.3.4.5 The enrollee timely files for continuation of benefits.

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

2.15.3.5.1 The enrollee withdraws the appeal;

2.15.3.5.2 Ten (10) calendar days pass after the Contractor 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;

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

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

2.15.3.6 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 Contractor receives the appeal.

2.15.3.7 Appeals shall be resolved no later than stated timeframes and all parties shall be informed of the Contractor's decision. If a determination is not made in accordance with the timeframes specified, the enrollee's request shall be deemed to have exhausted the Contractor'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.

2.15.4 Expedited Resolution for Appeals

2.15.4.1 The Contractor shall establish and maintain an expedited review process for appeals, when the Contractor 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.

2.15.4.2 The Contractor 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 Contractor receives the appeal request, whether the appeal was made orally or in writing.

2.15.4.3 The Contractor 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.

2.15.4.4 If an enrollee asks for an extension, the Contractor 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 Contractor of its obligation to resolve the enrollee's appeal as expeditiously as the enrollee's health condition requires, in accordance with federal regulations.

2.15.4.5 In the case of an expedited plan appeal denial, the Contractor 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.

2.15.5 Notice of Appeal Resolution

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

2.15.5.2 The Contractor 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.

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

2.15.6 Process for State Fair Hearings

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

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

2.15.6.3 The Contractor shall submit an evidence packet to LDH and to the enrollee, free of charge, within ten (10) business days from the time the Contractor receives notification of the hearing. The evidence packet shall be submitted to LDH in accordance with any prehearing instructions. The evidence packet shall include all necessary documents including the statement of matters (or, alternatively, the denial letter) and any medical records or other documents and/or records considered or relied upon by the Contractor and supporting the Contractor's adverse benefit determination and appeal resolution.

2.15.6.4 Within two (2) business days of notification of the state fair hearing request, the Contractor 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.

2.15.6.5 The Contractor shall designate an email address for all state fair hearing-related communications from LDH and any party to the state fair hearing.

2.15.6.6 The Contractor 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 Contractor sends the notice of appeal resolution that is not wholly in the enrollee's favor, in accordance with 42 C.F.R. §438.420(b).

2.15.6.7 The Contractor shall comply with all terms and conditions set forth in any orders and instructions issued by an administrative law judge.

2.15.6.8 If, at the enrollee's request, the Contractor continues or reinstates the benefits while the state fair hearing is pending, the benefits shall continue until one (1) of the following occurs:

2.15.6.8.1 The enrollee withdraws the state fair hearing request;

2.15.6.8.2 The state fair hearing officer issues a hearing decision adverse to the enrollee.

2.15.6.9 If the Contractor's action is reversed by the administrative law judge and services were not furnished while the plan appeal was pending, the Contractor 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 Contractor receives the notice reversing the determination.

2.15.6.10 The Contractor shall not create barriers to timely due process. The Contractor shall be subject to penalties if it is determined by LDH that the Contractor 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 calendar year. Examples of creating barriers shall include, but not be limited to:

2.15.6.10.1 Labeling grievances as inquiries and funneling them into an informal review;

2.15.6.10.2 Failure to inform enrollees of their rights to file grievances, appeals, and state fair hearings;

2.15.6.10.3 Failure to log and process grievances and appeals;

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

2.15.6.10.5 Failure to inform of continuation of benefits.

2.15.6.11 The Contractor 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.

2.16 Quality Management and Quality Improvement

LDH's Medicaid Managed Care Quality Strategy ("Quality Strategy") defines and drives the overall vision for advancing health outcomes and quality of care provided to Louisiana Medicaid enrollees. It establishes clear aims, goals, and objectives to drive improvements in care delivery and the outcomes and metrics by which progress will be measured. It articulates priority areas for quality improvement, and details the standards and mechanisms for desired outcomes, integration with population health priorities, and the advancement of health equity through reduction of health disparities. The Quality Strategy is a roadmap by which LDH shall use the managed care infrastructure to facilitate improvement in the clinical and non-clinical drivers of health, incentivizing the Contractor to attain quality goals and improve health outcomes.

2.16.1 General Requirements

2.16.1.1 The Contractor's quality management and quality improvement (QM/QI) and Quality Assessment and Performance Improvement (QAPI) programs shall align with LDH's priorities, goals and objectives as detailed in the Medicaid Quality Strategy.

2.16.1.2 The Contractor shall deliver quality care that enables enrollees to stay healthy, prevent poor outcomes and, if necessary, manage a chronic illness or disability. Quality care refers to:

- Clinical quality of physical health care;
- Clinical quality of behavioral health care focusing on recovery, resilience and rehabilitation;
- Access and availability of primary and specialty care providers and services;
- Continuity and coordination of care across settings and care transitions; and
- Enrollee experience with respect to quality, access, availability, cultural and linguistic appropriateness of services, and continuity and coordination of care.

2.16.1.3 The Contractor shall apply the principles of continuous quality improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

2.16.1.3.1 Quantitative and qualitative data collection with data-driven decision-making;

2.16.1.3.2 Up-to-date evidence-based practice guidelines consisting of explicit criteria developed by professional societies or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

2.16.1.3.3 Feedback provided by enrollees and providers in the design, planning, and implementation of CQI activities;

2.16.1.3.4 Issues identified by the Contractor or LDH; and

2.16.1.3.5 QM/QI requirements of this Contract applied to the delivery of both physical health services and behavioral health services.

2.16.1.4 The Contractor's QM/QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. Part 438, including, but not limited to, Subparts D and E.

2.16.1.5 The Contractor shall annually measure and report to the State on its performance, using the standard measures required by the State, and submit data to the State, as specified in this section.

2.16.2 Quality Assessment and Performance Improvement (QAPI) Program

2.16.2.1 The Contractor shall establish and implement a QAPI program, as required by this Contract and 42 C.F.R. §438.330(a)(1).

2.16.2.2 The QAPI program shall clearly define QM/QI structures and processes and assign responsibility to appropriate individuals.

2.16.2.3 At a minimum, the QAPI program shall:

2.16.2.3.1 Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities, including but not limited to, improving the Contractor's performance on measures specified in Attachment G;

2.16.2.3.2 Incorporate improvement strategies and performance improvement projects as defined by LDH;

2.16.2.3.3 Detect and address underutilization of high value services and overutilization of low value services, as guided by LDH's Quality Management Strategy. The Contractor shall work collaboratively with LDH to prioritize specific efforts anticipated to improve high quality, cost-effective care for enrollees. The Contractor shall implement at least one (1) initiative to reduce low-value care in a targeted area through coordination with network providers, including provider and enrollee education efforts. Within the first year of the Contract's operational start date, the Contractor shall propose its initiative to reduce low-value care in a targeted area, subject to LDH approval, based on feasibility, thoughtfulness of approach to enrollee and provider engagement, consistency with priorities of the LDH Quality Strategy, and alignment with nationally validated initiatives and frameworks.

2.16.2.3.4 Include collection and submission of performance measurement data in accordance with 42 C.F.R. §438.330(c);

2.16.2.3.5 Address the quality of covered services, including physical health and behavioral health services;

2.16.2.3.6 Include the Contractor's plan for improving the quality of care and patient safety based on improvement in health outcomes, rather than process or utilization outcomes;

2.16.2.3.7 Incorporate applicable reporting and monitoring requirements and activities;

2.16.2.3.8 Include mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs;

2.16.2.3.9 Include specific mechanisms to assess the quality and appropriateness of care provided to enrollees at risk for health disparities due to: race, ethnicity, sex, primary language, and sexual orientation;

2.16.2.3.10 Include QM/QI activities to improve health care disparities identified through data collection;

2.16.2.3.11 Detail the Contractor's Provider Support Plan; and

2.16.2.3.12 Be evaluated and updated at least annually by the Contractor.

2.16.2.4 The Contractor shall use the results of QAPI activities to improve the quality of physical health and behavioral health service delivery with appropriate input from enrollees and providers. The Contractor's annual QAPI evaluation shall describe how the Contractor solicited direct input from enrollees and providers and how the results of QAPI activities improved the quality of service delivery.

2.16.2.5 The Contractor shall submit its QAPI Program Description to LDH for written approval at least thirty (30) calendar days prior to the operational start date, and at least annually for the duration of the Contract. The QAPI program description shall include an annual QM/QI Work Plan that addresses issues identified by the Contractor, LDH, enrollees, and providers, and how those issues are tracked and resolved over time.

2.16.3 QAPI Governance

2.16.3.1 The Contractor's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the Contractor's governing body shall include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the Contractor.

2.16.3.2 The Contractor shall have sufficient mechanisms in place to solicit QM/QI feedback and recommendations from key stakeholders, enrollees and their families/caregivers, and providers, and use feedback and recommendations to improve performance.

2.16.3.3 The Contractor shall disseminate information about QAPI findings and improvement actions taken and their effectiveness to LDH and other key stakeholders as directed by LDH. At LDH's request, the Contractor may be required to conduct special focus studies.

2.16.3.4 The Contractor shall increase the alignment of assessment and treatment with best practice standards through policies.

2.16.3.5 The Contractor shall conduct peer review to evaluate the clinical competence and quality and appropriateness of care/services provided to enrollees.

2.16.3.6 The Contractor shall have appropriate staff participate in the LDH Quality Committee meetings and other quality improvement-related meetings/workgroups, as directed by LDH and shall establish and implement policies and procedures in order to address specific quality concerns.

2.16.4 QAPI Committee

The Contractor shall form a QAPI Committee that shall at a minimum include:

2.16.4.1 The Contractor's Medical Director must serve as either the chairman or co-chairman;

2.16.4.2 The Contractor's Behavioral Health Director;

2.16.4.3 Substantial involvement of medical and behavioral health providers serving the Contractor's enrollees;

2.16.4.4 Appropriate Contractor medical and behavioral health staff representing the various departments of the organization; and

2.16.4.5 An enrollee representative(s) and/or advocate(s) on the QAPI Committee.

The Contractor shall provide the LDH Medicaid Medical Director with ten (10) calendar days advance notice of all regularly scheduled meetings of the QAPI committee. The LDH Medicaid Medical Director, OBH Medical Director, Medicaid Quality Improvement Section Chief, or his/her designee(s), may attend the QAPI committee meetings at his/her option.

2.16.5 QAPI Committee Responsibilities

The QAPI Committee shall meet on at least a quarterly basis. Its responsibilities shall include:

2.16.5.1 Direct and review QM/QI activities and the QAPI Program overall;

2.16.5.2 Ensure that QAPI activities take place throughout the Contractor's organization and ensure that providers are involved in the QAPI Program;

2.16.5.3 Review and evaluate results of the QM/QI activities, recommend policy decisions, and suggest new and/or improved QM/QI activities;

2.16.5.4 Direct task forces/committees to identify, review, and address areas of concern in the provision of health care services to enrollees including instituting needed action and ensuring that appropriate follow up occurs;

2.16.5.5 Designate evaluation and study design procedures;

2.16.5.6 Review provider network performance, including individual PCP, specialized behavioral health provider, and practice quality performance measure profiling to identify and address patterns;

2.16.5.7 Report findings to appropriate executive authority, staff, and departments within the Contractor's organization;

2.16.5.8 Direct and analyze periodic reviews of enrollees' service utilization patterns;

2.16.5.9 Maintain written minutes of all committee and sub-committee meetings and submit meeting minutes to LDH. A copy of the signed and dated written minutes for each meeting shall be available after the minutes are approved and shall be available for review upon request and during on-site External Quality Review Organization (EQRO) reviews and during NCQA accreditation reviews;

2.16.5.10 Report an evaluation of the impact and effectiveness of the QAPI program to LDH annually;

2.16.5.11 Ensure that the QAPI committee chair, and/or the appropriate designee, participates in LDH's Quality Committee meetings and other quality related meetings as required by the *Quality Management and Quality Improvement* section of this Contract;

2.16.5.12 Work with other Contractor staff and subcontractors to establish policies and procedures to address specific quality concerns as required by the *Quality Management and Quality Improvement* section of this Contract; and

2.16.5.13 Update provider manuals and other relevant clinical content on a periodic basis as determined by the committee chairperson.

The Contractor shall take appropriate action to address service delivery, provider, and other QM/QI issues as they are identified, including, but not limited to, discussing and addressing identified quality of care concerns during regular and ad hoc QAPI Committee meetings.

2.16.6 QAPI Work Plan

The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted as part of readiness reviews and annually thereafter, and prior to implementation of revisions. The QAPI plan, at a minimum, shall:

2.16.6.1 Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;

2.16.6.2 Include processes to evaluate the impact and effectiveness of the QAPI Program;

2.16.6.3 Include a description of the Contractor staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities;

2.16.6.4 Describe the role of its providers in giving input to the QAPI Program;

2.16.6.5 Be exclusive to Louisiana Medicaid and shall not contain documentation from other state Medicaid programs or product lines operated by the Contractor; and

2.16.6.6 Describe the methods for ensuring data collected and reported to LDH is valid, accurate, and reflects providers' adherence to clinical practice guidelines as appropriate.

2.16.7 QAPI Reporting Requirements

2.16.7.1 The Contractor shall submit QAPI reports at least annually to LDH which, at a minimum, shall include:

2.16.7.1.1 Quality improvement (QI) activities;

2.16.7.1.2 Recommended new and/or improved QI activities; and

2.16.7.1.3 Results of the evaluation of the impact and effectiveness of the QAPI program.

2.16.7.2 LDH reserves the right to request additional reports as deemed necessary. LDH will notify the Contractor of additional required reports no less than sixty (60) calendar days prior to the due date of those reports.

2.16.7.3 The Contractor shall provide data reports, including, but not limited to, ad-hoc reports and reports for special populations to LDH using the specifications and format approved by LDH. The Contractor shall submit the reports based on the agreed upon dates established by the Contractor and LDH.

2.16.8 Performance Measures

2.16.8.1 Annually, the Contractor shall report on all HEDIS measures designated by LDH in Attachment G. The Contractor shall contract with an NCQA-certified HEDIS auditor to validate the processes of the Contractor in accordance with NCQA requirements. Audited HEDIS results shall be submitted to LDH, NCQA and LDH's EQRO annually according to NCQA's data submission timeline for health plans to submit final Medicaid HEDIS results.

2.16.8.2 The Contractor shall report on additional performance measures listed in and as specified in the Attachment G.

2.16.8.3 Reporting of quality measures shall include stratification of performance measure results across different populations with attention to geography, ethnicity, race, and disability status.

2.16.8.4 The Contractor shall have processes in place to monitor, self-report, and implement CQI on all performance measures.

2.16.8.5 The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.

2.16.8.6 The Contractor shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.

2.16.8.7 The tools and reports shall be flexible and adaptable to changes in the quality measurements required by LDH.

2.16.8.8 The Contractor shall maintain integrity, accuracy, and consistency in data reported. Upon request, the Contractor shall submit to LDH detail sufficient to independently validate the data reported.

2.16.9 Incentive Based Performance Measures

2.16.9.1 Incentive Based (IB) performance measures are measures that may affect PMPM payments and can be identified in Attachment G annotated with "$$".

2.16.9.2 LDH expressly reserves the right to modify IB performance measures. Any changes in the IB performance measures shall require an amendment to the Contract and LDH shall notify Contractor of such change prior to the start of the measurement year.

2.16.9.3 The Contractor's annual performance on IB performance measures in relation to LDH benchmark targets and the Contractor's prior performance shall affect its ability to earn back capitation payments related to the quality withhold described in the *Financial Incentives for MCO Performance* section.

2.16.10 Performance Measure Monitoring

2.16.10.1 The Contractor shall submit administrative encounter data to LDH or its designee upon request in a format that facilitates monitoring of the Contractor's performance on quality measures and benchmarks.

2.16.10.2 During the course of the Contract, the Contractor shall actively participate with LDH or its designee to review the results of performance measures.

2.16.10.3 Corrective action may be required for performance measures that do not reach the Department's performance benchmark. The standards by which the Contractor shall be surveyed and evaluated shall be at the sole discretion and approval of LDH.

2.16.10.4 LDH may impose liquidated damages, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.

2.16.11 Performance Improvement Projects

2.16.11.1 The Contractor shall implement an ongoing program of Performance Improvement Projects (PIPs) that focus on clinical and non-clinical performance measures as specified in 42 C.F.R. §438.330. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and

continuity and coordination of care; non-clinical PIPs include projects focusing on availability, accessibility, low-value care, addressing SDOH, and cultural competency of services.

2.16.11.2 The Contractor shall perform at least three (3) LDH-approved PIPs of which at least one must be a behavioral health PIP. LDH may require the Contractor to perform up to two (2) additional projects for a maximum of five (5) projects.

2.16.11.3 At LDH's request, prior to initiation of each LDH-directed PIP, the Contractor shall submit in writing a PIP proposal, in compliance with the **MCO Manual**, for LDH approval.

2.16.11.4 The Contractor shall ensure that CMS protocols for PIPs are followed and that all steps outlined in the CMS protocols for performance improvement projects are documented.

2.16.11.5 The Contractor shall, in collaboration with LDH, identify benchmarks and set achievable performance goals for each of its PIPs. The Contractor shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP and promoting sustained improvements.

2.16.11.6 PIPs shall be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction. Each project must involve the following:

2.16.11.6.1 Measurement of performance using objective quality indicators;

2.16.11.6.2 Implementation of interventions to achieve improvement in the access to and quality of care;

2.16.11.6.3 Evaluation of the effectiveness of the interventions; and

2.16.11.6.4 Planning and initiation of activities for increasing or sustaining improvement.

2.16.11.7 LDH, in consultation with CMS and other stakeholders, may require specific performance measures and PIP topics. The Contractor shall report the status and results of each PIP as specified in the **MCO Manual**. If CMS specifies a PIP, the Contractor shall participate and this shall count toward the state-approved projects.

2.16.11.8 Each project shall be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year.

2.16.12 Enrollee Satisfaction Surveys

2.16.12.1 The Contractor shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys.

2.16.12.2 The Contractor shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys.

2.16.12.3 The Contractor's vendor shall perform CAHPS Adult surveys and CAHPS Child surveys, including the Children with Chronic Conditions survey supplement.

2.16.12.4 Survey results and a description of the survey process shall be reported to LDH separately for each required CAHPS survey. CAHPS survey results shall be submitted to LDH, NCQA and LDH's EQRO annually according to NCQA's data submission timeline for health plans to submit final Medicaid CAHPS results.

2.16.12.5 The CAHPS survey results shall be reported to LDH or its designee for each survey question. These results may be used by LDH for public reporting. Responses shall be aggregated by LDH or its designee for reporting. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the Contractor at the time of the survey.

2.16.12.6 The surveys shall provide valid and reliable data for results.

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

2.16.12.8 The most current CAHPS Health Plan Survey for Medicaid Enrollees shall be used and include:

2.16.12.8.1 Getting Needed Care;

2.16.12.8.2 Getting Care Quickly;

2.16.12.8.3 How Well Doctors Communicate;

2.16.12.8.4 Health Plan Customer Service; and

2.16.12.8.5 Global Ratings.

2.16.12.9 The Contractor's vendor shall perform a LDH-approved behavioral health survey on an annual basis to be standardized across the Contractors. The survey results shall be reported to LDH on an annual basis.

2.16.13 External Review and Oversight of Contractor

2.16.13.1 The Contractor shall cooperate with LDH, CMS, LDH's EQRO and Outcomes Research and Evaluation Contractors, and any other LDH designees related to evaluation and monitoring of this Contract, the Contractor, or the Louisiana Medicaid managed care program.

2.16.13.2 The Contractor shall provide all information requested by LDH and/or its EQRO including, but not limited to, quality outcomes, quality improvement processes,

timeliness of, and enrollee access to, covered services, network adequacy and NCQA accreditation status.

2.16.13.3 The Contractor shall fully cooperate with the EQRO which shall conduct an annual independent review of the Contractor.

2.16.13.4 The Contractor shall comply with the EQRO's requests for information including, but not limited to, a review of the Contractor's QAPI Committee meeting minutes and annual medical record audits to ensure that it provides quality and accessible health care to Contractor enrollees, in accordance with standards contained in the Contract. Such audits shall allow LDH or its duly authorized representative to review individual medical records, identify and collect management data including, but not limited to, surveys and other information concerning the use of services and the reasons for enrollee disenrollment.

2.16.13.5 The standards by which the Contractor shall be surveyed and evaluated by the EQRO shall be at the sole discretion and approval of LDH. If deficiencies are identified, LDH shall determine the remedy or remedies as outlined in the *Contract Non-Compliance* section.

2.16.13.6 If the EQRO indicates that the quality of care is not within acceptable limits set forth in the Contract, LDH may penalize the Contractor in accordance with the Contract and may immediately terminate all enrollment activities and automatic assignment until the Contractor attains a satisfactory level of quality of care as determined by the EQRO and LDH.

2.16.13.7 The Contractor shall include a description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQRO findings in the Contractor's QAPI program.

2.16.14 Health Plan Accreditation

2.16.14.1 If the Contractor is NCQA accredited for its Medicaid product covered by this Contract as of the operational start date of this Contract, the Contractor shall maintain full NCQA accreditation throughout the term of this Contract.

2.16.14.2 If the Contractor is not NCQA accredited for its Medicaid product covered by this Contract, the Contractor shall attain such accreditation.

2.16.14.3 The Contractor's application for NCQA accreditation shall be submitted at the earliest point allowed by the organization. The Contractor shall provide LDH with a copy of all correspondence with NCQA regarding the application process and the accreditation requirements.

2.16.14.4 Within ten (10) calendar days of receipt of the final hard copy NCQA Accreditation report for each accreditation cycle, the Contractor shall provide LDH with a copy of its final accreditation report including:

2.16.14.4.1 Accreditation status, survey type, and level (as applicable);

2.16.14.4.2 Accreditation results, including recommended actions or improvements, corrective action plan, and summaries of findings; and

2.16.14.4.3 Expiration date of the accreditation.

2.16.14.5 The Contractor shall provide LDH with updates of its NCQA accreditation status if there are any changes within the accreditation period or upon request by LDH.

2.16.14.6 If the Contractor achieves provisional accreditation status from NCQA:

2.16.14.6.1 LDH may restrict automatic and voluntary enrollment in the Contractor's plan; and

2.16.14.6.2 LDH shall require the Contractor to initiate a corrective action plan within thirty (30) calendar days of receipt of the Final Report from NCQA and work to address the findings contributing to the provisional accreditation status.

2.16.14.7 The Contractor's failure to attain full NCQA accreditation under this Contract or failure to maintain full NCQA accreditation at any time may be considered a breach of the Contract and may result in termination of the Contract.

2.16.14.8 If the Contractor subcontracts with a third party (which is either a part of the Contractor's parent organization or wholly independent) for behavioral health services, the subcontractor shall be accredited by NCQA as a managed behavioral health organization, or be working towards and receive accreditation within the Contract term.

2.16.15 Enrollee Advisory Council

As specified in **the MCO Manual**, the Contractor shall establish an Enrollee Advisory Council to enhance the service delivery system, improve enrollee experience, and allow participation in providing input on policy and programs. Such Council shall be in compliance with the requirements in the **MCO Manual**.

2.16.16 Provider Supports for Quality Improvement

2.16.16.1 The Contractor shall provide support to providers tailored to advance state priorities and ensure providers' ability to achieve the goals outlined in the Quality Strategy. Such supports shall assist providers in clinical transformation and care improvement efforts at a regional and practice level.

2.16.16.2 As part of the Contractor's QAPI Plan, it shall develop and maintain a Provider Support Plan, which shall be updated on an annual basis. The Provider Support Plan shall:

2.16.16.2.1 Be developed as a component of the QAPI program; provider support activities should relate to improvement in specific health outcomes; and

2.16.16.2.2 Include: (a) a list of provider supports; (b) how the Contractor will provide in-person, online, and practice-level and regional collaborative support

opportunities; (c) all planned technical support activities including the Contractor's plan for sharing relevant data; (d) metrics to evaluate provider engagement and related improvements; and (e) detailed information regarding how its proposed provider supports activities will advance the aims, goals, and objectives outlined within LDH's Quality Strategy.

2.16.16.3 The Contractor shall provide quality improvement support to network providers during the initiation and implementation of quality and population health interventions, as outlined in the Quality Strategy and in coordination with the Louisiana Medicaid Quality Committee, or as otherwise specified by LDH.

2.16.16.4 The Contractor shall provide an opportunity for providers (in-person, online, routine/ad-hoc) to raise local challenges and exchange best practices related to quality and population health interventions, as outlined in the Quality Strategy and other LDH transformation initiatives.

2.16.16.5 The Contractor shall communicate with the LDH Medicaid Medical Director or designated primary contact in order to raise regional issues related to quality and population health interventions, as outlined in the Quality Strategy and as otherwise specified by LDH.

2.16.17 Fidelity to Evidence-Based Practices in Behavioral Health Care

2.16.17.1 The Contractor shall establish a fidelity-monitoring plan for Evidenced Based Practice providers to ensure providers' adherence to evidence-based and evidence-informed practices to ensure the core elements of the intervention are maintained and minimum fidelity standards are met. The fidelity monitoring plan shall at a minimum include the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods.

2.16.17.2 The providers maintain fidelity monitoring for Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Homebuilders and Assertive Community Treatment (ACT) as part of the certification/credentialing process. The Contractor shall maintain Memorandums of Understanding (MOUs) with the fidelity monitoring agencies for Family Functional Therapy, Multisystemic Therapy, and Homebuilders. The MOUs outline a collaborative protocol between the Contractor and the monitoring agencies to ensure the appropriate exchange of fidelity reports and other quality reports.

2.16.17.3 The Contractor shall manage the fidelity monitoring process for Assertive Community Treatment (ACT) providers to ensure minimum fidelity standards utilizing the LDH-specified ACT Monitoring tool. The Contractor shall ensure their staff are properly trained on utilization of the identified ACT Monitoring tool.

2.16.17.4 A formal fidelity-monitoring plan shall be submitted as part of readiness reviews, which includes at a minimum the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods. The monitoring system shall include a formalized

monitoring review process of all providers' performance on an ongoing basis including a procedure for formal review with site-visits. Site visits shall be conducted according to a periodic schedule individualized by provider type determined by the Contractor and approved by LDH. Reports shall be submitted to LDH according to the frequency established in the fidelity monitoring plan submitted to LDH, but no less than once per year.

2.16.18 Best Practices in Children's Behavioral Health Residential Treatment

The Contractor shall advance initiatives aimed at increased alignment of children's behavioral health residential programming with national best practice standards. The Contractor shall utilize authorization, continued stay review, and discharge planning protocols that support the implementation of best practices. The Contractor shall participate in planning and implementation of these initiatives with LDH, and collaborate to develop an implementation monitoring plan and provide assistance to providers in collecting and reporting on best practice-related performance indicators. Performance indicators may include reducing restraints and seclusions, increased employment of peer professionals, increased family involvement concurrent with the youth's residential stay [family involvement includes family voice in treatment planning], family support/skills training/therapy to support the family's ability to receive the youth home, frequent and ongoing contact with family in the form of phone calls and visits; and six-twelve (6-12) month post-discharge outcomes data regarding successful integration into the home and community.

2.16.19 Adverse Incident and Quality of Care Concerns Management and Reporting

2.16.19.1 The Contractor shall develop and implement adverse incident management policies and procedures for the specialized behavioral health population, which enable the Contractor to identify and address service gaps and to timely identify, address, and remediate harms, assess the effectiveness of the corrective or remedial actions, and reduce risks of recurrent harm at both the Contractor and community provider levels.

2.16.19.2 The Contractor shall establish reporting and investigation protocols for significant incidents, including mortalities, and conduct mortality reviews using a multidisciplinary team in accordance with the DOJ Agreement and associated documents, and subject to LDH approval.

2.16.19.3 The Contractor shall provide training, on no less than an annual basis, to community providers on adverse incident management requirements.

2.16.20 Outcome Assessment for Behavioral Health Services

2.16.20.1 The Contractor shall assess the treatment progress and effectiveness of specialized behavioral health services for both children and adults using standardized clinical outcome tools and measures, according to the guidelines in the **MCO Manual**.

2.16.20.2 The Contractor shall ensure providers and appropriate Contractor staff are adequately trained and/or certified in the use of such tools and such training and/or certification is current.

2.16.20.3 The Contractor shall be responsible for collection of outcome data, data validation activities, and reporting to LDH.

2.16.21 Voluntary Managed Care Incentive Program

2.16.21.1 LDH may make incentive payments up to five percent (5%), in total, above the approved capitation payments attributable to the enrollees or services covered by the Approved Incentive Arrangements, as defined in LDH's Managed Care Incentive Program (MCIP) Protocol, implemented by LDH. These incentive payments will support the activities, targets, performance measures, or quality-based outcomes specified in LDH's quality strategy.

2.16.21.2 Each MCO has the right to determine whether to participate in one or more of the Approved Incentive Arrangements implemented by LDH. The MCO shall receive incentive payments under this Section for only those Approved Incentive Arrangements in which it participates. At the MCO's sole discretion, a participating MCO may contract with one or more third parties to assist in its achievement of those Approved Incentive Arrangements, including specific provisions pertaining to the rights and obligations of the MCO and such third parties; eligibility for participation; payment amount and timing; recovery of payments (including the amount, time and manner/method); and other such terms particular to that Approved Incentive Arrangement as mutually agreed upon in the contract between the MCO and such third party.

2.16.21.3 LDH will, for each Approved Incentive Arrangement to be implemented, specify the activities, targets, performance measures, or quality-based outcomes to be achieved and how each will be evaluated. LDH will not implement any Approved Incentive Arrangement that is not consistent with 42 C.F.R. §438.6(b)(2) and this Section, including:

2.16.21.3.1 Approved Incentive Arrangements will be for a fixed period of time and performance will be measured during the rating period under the Contract in which the Approved Incentive Arrangement is applied.

2.16.21.3.2 Approved Incentive Arrangements will not be renewed automatically.

2.16.21.3.3 Approved Incentive Arrangements will be made available to both public and private contractors under the same terms of performance.

2.16.21.3.4 Neither an MCO's participation in the managed care incentive program, nor any Approved Incentive Arrangement, will be conditioned on the MCO entering into or adhering to an intergovernmental transfer agreement.

2.16.21.4 Each Approved Incentive Arrangement shall define the quality strategy objectives.

2.16.21.5 For each measurement year ending on or after December 31, 2020, LDH will evaluate performance relative to the specified activities, targets, performance measures, or quality-based outcomes to be achieved for the Approved Incentive Arrangement for that measurement year. LDH's evaluation will be based on documentation, submitted by the MCO, reflecting performance.

2.16.21.6 LDH shall timely notify the Contractor regarding achievement for the specified activities, targets, performance measures or quality-based outcomes for the Approved Incentive Arrangement for that measurement year. In the event LDH finds a deficiency, LDH will notify the Contractor of its findings, including the portion of the incentive payments made attributable to such deficiency. Upon request of the Contractor, LDH may defer recoupment, and the Contractor and LDH may confer regarding LDH's findings, proposed action and opportunity for cure. Upon final determination by LDH, which shall be final and not subject to appeal, LDH may recoup from the Contractor the portion of the incentive payments made attributable to any uncured deficiency. All LDH recoupments made from MCOs pursuant to this Section shall be made in accordance with the recoupment terms established by LDH, which terms shall be provided to the MCOs in writing at least thirty (30) days in advance of LDH recoupment from the MCOs.

2.16.21.7 An MCO choosing to participate in Approved Incentive Arrangements implemented under this Section shall ensure that any contracts the MCO may have with any third party to fulfill the obligations under this Section contain provisions clearly providing for the MCO's right of recovery in situations whereby LDH recoups MCIP payments from the MCO. An MCO's activities to recover such payments, through recoupment, withhold or otherwise, are not subject to the prior notification requirement under the *Fraud, Waste and Abuse Prevention* section, or any other notice and reporting obligation set forth in this Contract unless otherwise required by the terms of recoupment specified by LDH under this Section.

2.16.21.8 An MCO's participation in one or more Approved Incentive Arrangements shall have no impact on the MCO's rights or obligations under this Contract, except as it relates specifically to the MCIP Program. An MCO's participation in an Approved Incentive Arrangement does not represent a binding obligation on the MCO to achieve the approved targeted health outcomes, and failure to achieve such outcomes shall not be considered a breach of this Contract. Further, except for recoupment of MCIP payments, either directly or via offset, no penalty shall be applied for failure to achieve targeted outcomes. The aforementioned penalty limitation shall not apply to instances of the MCO's fraudulent conduct. In the event of a conflict with other terms of this Contract, the provisions of this Section and LDH's MCIP Protocol shall prevail.

2.17 Value-Based Payment

2.17.1 Value-Based Payment (VBP) Overview

The Contractor shall develop and implement a VBP Strategic Plan for achieving the performance benchmarks in the **MCO Manual** and paying providers based on performance. The Contractor's VBP strategy shall pertain to measurable outcomes that are meant to improve the health of

populations (better health), enhance the experience of care for individuals (better care), effectively manage Medicaid per capita care costs (lower costs), and be designed to meet or exceed the VBP withhold requirements in this Contract.

In developing its VBP Strategic Plan, the Contractor shall refer to this Contract, the **MCO Manual** and the Alternative Payment Method (APM) Framework developed by the Health Care Payment Learning and Action Network (HCP-LAN).

2.17.2 Minimum VBP Threshold and Qualifying VBP Arrangements

A portion of the Contractor's annual VBP withhold described in the *Financial Incentives for MCO Performance* section shall be tied to the Contractor's demonstration that it has met the minimum VBP threshold established as defined by LDH in accordance with this Contract and the **MCO Manual**. Unless otherwise modified by LDH, the minimum VBP threshold for each measurement year is as follows:

2.17.2.1 CY2020

2.17.2.1.1 Contractual arrangements linked to a VBP model account for at least twenty percent (20%) of total provider payments in the measurement year and the Contractor's total potential provider incentive payments related to this measurement year exceed four (4) million dollars in total provider payments, or

2.17.2.1.2 The Contractor's total potential provider incentive payments exceed eight (8) million dollars in total provider payments

2.17.2.2 CY2021

2.17.2.2.1 Contractual arrangements linked to a VBP model account for at least thirty percent (30%) of total provider payments in the measurement year and the Contractor's total potential provider incentive payments related to this measurement year exceed five (5) million dollars in total provider payments, or

2.17.2.2.2 The Contractor's total potential provider incentive payments exceed ten (10) million dollars in total provider payments.

2.17.2.3 CY2022 and Future Years

2.17.2.3.1 Contractual arrangements linked to a VBP model account for at least forty percent (40%) of total provider payments, and the Contractor's total potential provider incentive payments exceed six (6) million dollars in total provider payments, or

2.17.2.3.2 The Contractor's total potential provider incentive payments exceed twelve (12) million dollars in total provider payments

2.17.3 Qualifying VBP Arrangements

The Contractor may only report a provider payment model as a VBP arrangement if the following conditions are met:

2.17.3.1 The payment model includes a Category 2A foundational payment as one component of a broader payment model that includes Category 2C or 3 APMs for the same provider(s); and/or

2.17.3.2 The payment model falls within Categories 2C, 3 and 4 of the LAN Alternative Payment Model Framework; and

2.17.3.3 The payment model is linked to applicable incentive-based measures from Attachment G.

2.17.4 Physician Incentive Plan

2.17.4.1 In accordance with 42 C.F.R. §422.208 and §422.210, the Contractor may operate a Physician Incentive Plan but specific payment cannot be made directly or indirectly under a Physician Incentive Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

2.17.4.2 The Contractor's Physician Incentive Plans shall be in compliance with 42 C.F.R. §438.3(i), §422.208 and §422.210 and the **MCO Manual**.

2.17.4.3 Any sub-capitation arrangement with contracted providers is considered a Physician Incentive Plan.

2.17.4.4 The Contractor shall provide an annual written assurance to LDH that either the Contractor is not operating any Physician Incentive Plans that put providers at "substantial financial risk" as defined in 42 C.F.R. §422.208; or the Contractor is operating Physician Incentive Plans that put providers at "substantial financial risk" as defined in 42 C.F.R. §422.208 and those Plans meet all applicable federal requirements.

2.17.4.5 The Contractor shall provide written notification to LDH at least thirty (30) calendar days prior to implementation of any new Physician Incentive Plan or when an existing Plan is modified. The written notification shall include a list of participating providers and specify that all terms and conditions of the Plans are compliant with all applicable federal regulations. LDH reserves the right to request additional documentation, including, but not limited to, the actual incentive plans.

2.17.4.6 The Contractor shall provide the information specified in 42 C.F.R. §422.210(b) regarding its Physician Incentive Plans to any Medicaid enrollee upon request.

2.17.5 VBP Strategic Plan

2.17.5.1 A portion of the Contractor's annual VBP withhold described in the *Financial Incentives for MCO Performance* section shall be tied to the Contractor's submission

and update of a VBP Strategic Plan in accordance with the Contractor's proposal, this Contract, and the **MCO Manual**. The Contractor's VBP Strategic Plan shall be revised based on further LDH guidance and submitted on March 1, 2020 in a format specified by LDH.

2.17.5.2 The Contractor's VBP strategy shall place emphasis on the establishment of provider payment arrangements designated as Category 3 and 4 models and the evolution of providers along the LAN APM model continuum with consideration of provider readiness to take on financial risk, and recognize that some providers may not ever be in a position to take on financial risk models.

2.17.5.3 The VBP Strategic Plan, at a minimum, shall include the following:

2.17.5.3.1 The Contractor's overall approach to VBP;

2.17.5.3.2 Specific models and VBP arrangements proposed for implementation, expansion, or modification, including those related to preferred VBP models as described in this section;

2.17.5.3.3 The Contractor's strategy to align Medicaid Managed Care VBP payment models with CMS advanced APMs and multi-payer VBP models;

2.17.5.3.4 The Contractor's estimated primary care expenditures and related VBP payment methodologies, including proposed changes to these expenditures over the course of the Contract;

2.17.5.3.5 The Contractor's PCP assignment and provider attribution methodologies and processes, including addressing provider or enrollee requests for review of assignment/attribution for enrollees;

2.17.5.3.6 VBP milestones and timelines for achievement;

2.17.5.3.7 Specific health outcomes and efficiency goals that shall be tracked and evaluated for performance as part of each VBP model in alignment with the measures specified in the **MCO Manual**;

2.17.5.3.8 Description of data sharing arrangements with participating providers, including how shared performance data align with the measures and VBP models, and methods and frequency for collecting and sharing performance data with providers in a standardized format consistent with this Contract and the **MCO Manual**;

2.17.5.3.9 Approaches to develop and assess provider readiness for VBP and evolution along the VBP continuum;

2.17.5.3.10 Description of activities that support provider education, primary care practice transformation, and performance improvement;

2.17.5.3.11 Barriers to increasing VBP and advancing to higher LAN APM categories; and

2.17.5.3.12 Actions to overcome barriers to and increase participation in VBP.

2.17.5.4 The Contractor shall submit updates to the VBP Strategic Plan to LDH annually by November 1, including barriers, solutions, lessons learned, successes, status, supportive data, and other pertinent information to the VBP strategy and delivery system improvement efforts. The Contractor's update shall include lessons learned with PCP assignment/attribution and VBP data sharing and propose modifications as appropriate.

2.17.5.5 The Contractor shall annually evaluate the impact of its VBP strategy on access, utilization, quality, and cost, as well as return on investment, and report to LDH as part of its VBP Strategic Plan update, including modifications made to improve performance outcomes.

2.17.5.6 As part of the annual written VBP Strategic Plan, the Contractor shall present its Plan, relevant updates, and lessons learned to LDH.

2.17.6 Inventory of VBP Arrangements

The Contractor shall maintain an inventory of providers with which it has entered into VBP arrangements by LAN category and provider type. The inventory shall be submitted as part of the VBP Strategic Plan, updated at least annually, and submitted with the required Strategic Plan update.

2.17.7 VBP Data Sharing and Collaborative Efforts

2.17.7.1 The Contractor shall dedicate resources for provider outreach and education related to VBP models, primary care practice transformation, assistance with data and report interpretation, and other activities to support provider's VBP readiness and performance improvement.

2.17.7.2 The Contractor shall implement processes to share data and performance reports with participating VBP providers on a regular basis, no less than monthly. The Contractor shall consider provider capabilities for accessing, utilizing and acting on data shared in different formats as well as provider capabilities to share such data internally. The Contractor shall identify and incorporate aligned data sharing approaches and policies with providers to support VBP models and reduce administrative burden on providers.

2.17.7.3 The Contractor shall fully participate in LDH-directed VBP Workgroups and payment reform initiatives implemented throughout the term of the Contract designed to pay providers for improving quality and efficiency of care and simplifying administration. The Contractor shall enable providers to engage in VBP arrangements that allow the provider to have graduated opportunities for earning performance incentive payments and to obtain interim performance payments pending reconciliation based on the Contractor's final determination of quality and financial results as applicable to the model.

2.17.7.4 The Contractor shall work collaboratively with LDH, providers, and with other MCOs to develop common measure specifications, address attribution challenges, and work to align data collection processes, baseline data, and reports for providers engaged in VBP arrangements.

2.17.8 Patient-Centered Medical Home (PCMH)

2.17.8.1 The Contractor shall promote primary care practices' attainment of PCMH Recognition or Accreditation status from a CMS-approved nationally recognized accreditation program or participation in the Medicare Comprehensive Primary Care Plus Program.

2.17.8.2 The Contractor shall facilitate the capacity of primary care practices to function as a PCMH by sharing enrollee-specific information, including, but not limited to, health needs assessment, service utilization, and population health stratification data.

2.17.9 Preferred VBP Arrangements

2.17.9.1 Preferred VBP arrangements are priorities for LDH based on the potential to improve health care and cost-efficiency. The Contractor shall implement three (3) different types of preferred VBP models from the list below within three (3) years of the Contract operational start date.

2.17.9.1.1 Patient-centered medical home models that are part of a broader payment model that includes Category 2C or 3 APMs and which support the integration of behavioral health, SDOH, and populations with special health care needs;

2.17.9.1.2 Models supporting physical and behavioral health integration;

2.17.9.1.3 Hospital VBP arrangements;

2.17.9.1.4 Maternity-focused VBP arrangements;

2.17.9.1.5 Accountable Care Organizations; and

2.17.9.1.6 Other models as identified by LDH.

2.17.9.2 The Contractor shall indicate in its VBP Strategic Plan and subsequent updates to the Plan the preferred VBP arrangements it intends to implement over the Contract period.

2.17.10 Enrollee Attribution in VBP Arrangements

2.17.10.1 VBP models involve enrollees being clearly attributed to providers for consideration of quality performance, and in some cases, total cost of care performance of the provider's attributed population, as defined in the VBP model and payment arrangements. The Contractor shall develop and share its attribution approach for VBP arrangements with LDH and network providers in a transparent and accessible manner.

2.17.10.2 The Contractor shall collaborate with providers engaged in VBP models to develop and maintain an accurate, up-to-date list of attributed enrollees and associated providers. At least monthly, the Contractor shall share complete lists of attributed enrollees with VBP providers. At a minimum, the Contractor shall share performance and claims data for attributed enrollees with VBP providers on a quarterly basis.

2.17.10.3 For a VBP arrangement that includes primary care, the Contractor shall attribute enrollees to the same provider which has been selected, either by choice or assignment, as the enrollee's PCP. The Contractor shall educate providers on how to access, utilize, and share data on attributed enrollees.

2.17.11 Mechanisms for Providers to Dispute Enrollee Attribution

2.17.11.1 The Contractor shall have a process by which a provider may dispute the Contractor's attribution of an individual enrollee in relation to a VBP arrangement as it relates to the measurement of the provider's quality or financial performance in the model. The Contractor shall inform providers of such dispute process and must respond to and address provider complaints related to individual enrollee attribution within fifteen (15) calendar days of receipt.

2.17.11.2 For attribution to primary care providers, the Contractor shall attribute enrollees to their assigned PCP.

2.17.11.3 The Contractor shall consider altering its attribution and related PCP assignment when an enrollee is regularly seeing a different provider for primary care services than the PCP to which the enrollee has been attributed and if an enrollee has not seen the attributed PCP in the past twelve (12) months.

2.17.11.4 The Contractor shall have clear methods for adjusting its PCP assignment and VBP attribution methodologies based on data analysis, and shall implement LDH-directed PCP assignment and VBP attribution policies and methodologies to ensure uniformity across MCOs.

2.17.12 Data Sharing in VBP Arrangements

2.17.12.1 The Contractor shall work collaboratively with providers involved in VBP arrangements, including promptly sharing data and minimizing administrative burdens for providers.

2.17.12.2 The Contractor's VBP approach shall be designed to align financial incentives for plans and providers and build shared capacity to improve care through data and collaboration.

2.17.12.3 The Contractor shall offer information and tools for providers to query data sets, including information and tools such as:

2.17.12.3.1 Timely and actionable data regarding cost, utilization and quality for attributed enrollee populations;

2.17.12.3.2 Contact, health screening, and health risk information for attributed enrollees;

2.17.12.3.3 Identification of high utilizers and other pertinent information;

2.17.12.3.4 Real-time data related to Admission, Discharge, and Transfers; and

2.17.12.3.5 Enrollee registries.

2.17.12.4 The Contractor shall comply with provider profiling and data sharing formats and frequency specifications issued by LDH.

2.17.12.5 The Contractor's data sharing policies and agreements with providers shall address and comply with applicable federal and state data privacy and security requirements.

2.17.12.6 The Contractor shall employ and clearly identify provider network representatives to support providers that are engaged in VBP arrangements to better understand and act on data to improve quality and manage costs of care.

2.17.12.7 The Contractor shall ensure that it receives encounter and other data needed under VBP arrangements to meet its obligations under this Contract.

2.17.13 Financial Benchmarks, Shared Savings Calculations, and Risk Mitigation

2.17.13.1 The Contractor's financial benchmarks in VBP models shall incentivize high-quality, efficient care, enable accountability, and establish targets that fairly reward provider organizations. The Contractor shall risk-adjust provider payment rates when feasible and appropriate in VBP models to reflect the risk of the attributed population.

2.17.13.2 The Contractor shall transparently communicate to providers the shared savings and risk-sharing parameters involved in participating in a VBP model, such that providers can access the information they need to fully comprehend the opportunities and risks associated with participation. The Contractor shall clearly articulate when and how it will determine provider financial performance and how it will set the targets.

2.17.13.3 The Contractor shall offer providers in good standing and with prior VBP experience with the Contractor the option to obtain a portion of anticipated VBP payments prospectively based on interim financial and quality performance results rather than waiting for potential payments from shared savings calculations after the end of the performance period.

2.17.13.4 The Contractor shall offer providers an audit or appeal process on VBP budget and shared savings or shared risk calculations.

2.17.13.5 For shared risk arrangements, the Contractor shall consider whether and how to use stop-loss or other risk protections in consultation with participating providers, and consider provider size, financial stability, the potential for random variation in medical expenditures of a population, and a provider's VBP experience. The Contractor shall share financial modeling data with providers to demonstrate

potential changes in provider payments prior to accepting downside risk arrangements.

2.17.14 Accountable Care Organizations

2.17.14.1 By January 2021, the Contractor shall contract with and maintain at least one (1) Accountable Care Organization (ACO) Agreement, as described in this Section and as further specified by LDH. Such ACO Agreements shall have the potential to care for at least two thousand (2,000) MCO enrollees. The Contractor shall ensure that the provider entity is able to meet all ACO requirements specified by LDH including requirements related to governance, care delivery, care coordination and care management, enrollee protections, and Total Cost of Care (TCOC) accountability.

2.17.14.2 At a minimum, only agreements between the Contractor and an ACO that meet the following criteria shall be considered by LDH to meet the Contractor's obligation to enter into at least one (1) ACO agreement. The ACO shall:

2.17.14.2.1 Have a governing board that is a separate entity from another governing board of a related entity and that has authority to execute the services and functions of the ACO;

2.17.14.2.2 Have a mechanism for shared governance among the providers who are members of the ACO including providing meaningful participation in the composition and control of the ACO's governing body for participating primary care and other providers (or their designated representatives);

2.17.14.2.3 Have, unless LDH approves the recognition of an ACO with an alternate governing body composition, majority control of the governing body held by ACO provider participants and at least thirty-three percent (33%) control by ACO provider participants that are independent of hospital-based entities;

2.17.14.2.4 Have a structure that reflects the importance of primary care including clear opportunities for primary care providers to participate in ACO governance, clinical policy development, and revenue sharing.

2.17.14.2.5 Have a leadership and management structure and opportunities for provider, enrollee and consumer advocate participation designed to ensure that the ACO meets its administrative, financial, operational and clinical responsibilities for Medicaid MCO enrollees;

2.17.14.2.6 Demonstrate its ability to coordinate an enrollee's care across the continuum, including sufficient PCP access throughout the proposed ACO service area to comply with the requirements for access and timeliness of care in this Contract as well as the capacity, tools, and authority to integrate and manage physical and behavioral health care, from preventive services to hospital-based care;

2.17.14.2.7 Demonstrate its analytic capacity to recognize utilization and cost patterns, identify critical gaps in care and points of intervention at the individual level and support data driven decision-making and real time interventions;

2.17.14.2.8 Demonstrate its health information and systems capabilities including the ability to submit claims and encounter data to the Contractor, receive aggregated performance data, utilize data to identify gaps in care and enhance patient management; and

2.17.14.2.9 Prior to assuming risk, be able to demonstrate financial solvency sufficient to absorb the risk.

2.17.14.2.10 In cases in which the composition of the ACO's governance does not meet the requirements of this section, the Contractor must describe to LDH where the ACO differs from these requirements and how the ACO will provide meaningful representation in ACO governance by primary care providers and other providers independent of hospital entities.

2.17.14.3 The Contractor shall fully comply with ACO operational, quality, and financial reporting requirements as established by LDH.

2.17.14.4 The Contractor shall have a written plan for its monitoring and oversight of the performance of any ACO subcontractors which shall be considered Material Subcontractors under this Contract.

2.17.14.5 The Contractor shall submit its ACO model contract and details of its ACO payment methodology to LDH in advance of contracting with an ACO and shall comply with federal and state requirements applicable to such an ACO contract(s), including 42 C.F.R. § 438.6(c) and related provisions where applicable.

2.17.14.6 The Contractor's ACO agreements shall:

2.17.14.6.1 Be subject to review and approval by LDH;

2.17.14.6.2 Not in any way replace, modify, or invalidate any responsibilities the Contractor has under this Contract; and

2.17.14.6.3 Commit the Contractor to provide contracted ACOs with the supports required under this Contract for VBP arrangements, including but not limited to:

2.17.14.6.3.1 Data supports, such as a list of the enrollees attributed to each ACO and periodic updates to such list;

2.17.14.6.3.2 Assistance identifying high risk enrollees, including enrollees who may benefit from care management activities; and

2.17.14.6.3.3 Financial model technical assistance, such as education and support explaining the total cost of care financial model for ACOs.

2.17.14.7 The Contractor shall establish a continuous quality improvement model to evaluate ACO outcomes on quality, access and efficiency measures and make modifications as needed. No later than November 2022, as part of its VBP Strategic Plan update, the Contractor shall:

2.17.14.7.1 Provide data and an analysis regarding the initial results of the ACO to LDH; and

2.17.14.7.2 Report on the results of the ACO Initiative in the presence of LDH and provider stakeholders in the applicable regions and make recommendations for successful components of the Initiative to be made part of the Contractor's ongoing ACO and VBP arrangements going forward.

2.17.14.8 Pursuant to the results of LDH's collaborative efforts with MCOs and the ACOs, beginning in 2023, the Contractor may be required to offer to contract with ACOs that meet LDH qualification standards.

2.18 Claims Management

2.18.1 Functionality

2.18.1.1 The Contractor shall maintain an electronic claims management system that shall:

2.18.1.1.1 Uniquely identify the attending and billing provider of each service;

2.18.1.1.2 Identify the date of receipt of the claim by the Contractor as indicated by the date stamp on the claim;

2.18.1.1.3 Identify real-time accurate history with dates of adjudication results of each claim such as paid, denied, pended, adjusted, voided, appealed, etc., and follow up information on disputed claims;

2.18.1.1.4 Identify the date of payment as indicated on the check or other form of payment, and the number of the check or electronic funds transfer (EFT);

2.18.1.1.5 Identify all data elements as required by LDH for encounter data submission as stipulated in this Section of the Contract and the **MCO Manual**;

2.18.1.1.6 Accept submission of paper-based claims and electronic claims by network providers, and non-participating providers;

2.18.1.1.7 Accept submission of electronic adjustments and void transactions;

2.18.1.1.8 Accept submission of paper adjustments and void transactions;

2.18.1.1.9 Have capability to pay claims at $0.00; and

2.18.1.1.10 For the purpose of this Section, identify means to capture, edit, and retain.

2.18.1.2 The Contractor shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the Contractor 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.

2.18.1.3 The Contractor shall assume all costs associated with claims processing, including costs for processing and/or reprocessing encounters.

2.18.1.4 The Contractor shall provide online and phone-based capabilities to providers to obtain claim processing status information.

2.18.1.5 The Contractor shall support a CAQH/CORE compliant interface to the automated clearinghouse (ACH) that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

2.18.1.6 The Contractor shall have procedures, subject to LDH approval, available to providers in written and web form for the acceptance of claim submissions which include:

2.18.1.6.1 The process for documenting the date of actual receipt of non-electronic claims and date and time of receipt of electronic claims;

2.18.1.6.2 The process for reviewing claims for accuracy and acceptability in accordance with 42 C.F.R. §438.242(b)(3);

2.18.1.6.3 The process for prevention of loss of such claims; and

2.18.1.6.4 The process for reviewing claims for determination as to whether claims are accepted as clean claims.

2.18.1.7 The Contractor shall not employ off-system or gross adjustments when processing corrections for payment errors, unless the Contractor requests and receives prior written approval from LDH.

2.18.1.8 For purposes of network management, the Contractor shall notify all network providers to file claims associated with covered services for its enrollees directly with the Contractor.

2.18.1.9 The Contractor shall modify its claims billing and processing to be consistent with industry norms within thirty (30) calendar days of notice by LDH.

2.18.2 Claims Processing

2.18.2.1 The Contractor shall ensure that all provider claims are processed according to the following timeframes:

2.18.2.1.1 Within five (5) business days of receipt of a claim, the Contractor 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;

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

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

2.18.2.1.4 Pay or deny all (100%) pended claims within sixty (60) calendar days of the date of receipt.

2.18.2.2 The Contractor may pend claims submitted by providers that are the subject of a payment suspension due to a credible allegation of fraud in accordance with 42 C.F.R. §455.23 for the duration of the payment suspension. Once the suspension period has ended, the Contractor shall adjudicate any previously pended claims in accordance with the timeframes above.

2.18.3 Rejected Claims

2.18.3.1 The Contractor may reject claims because of missing or incomplete information. Paper claims that are received by the Contractor that are screened and rejected prior to scanning shall be returned to the provider with a letter notifying them of the rejection. Paper claims received by the Contractor that are scanned prior to screening and then rejected, are not required to accompany the rejection letter.

2.18.3.2 The Contractor shall not include a rejected claim on the Remittance Advice (RA) because it will not have entered the claims processing system.

2.18.3.3 In the claims rejection letter, the Contractor 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:

2.18.3.3.1 The date the letter was generated;

2.18.3.3.2 The enrollee's name;

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

2.18.3.3.4 The date of each service;

2.18.3.3.5 The patient account number assigned by the provider;

2.18.3.3.6 The total billed charges;

2.18.3.3.7 The date the claim was received; and

2.18.3.3.8 The reasons for rejection.

2.18.4 Pended Claims

If a claim is received, but additional information is required for adjudication, the Contractor may pend the claim and request in writing all necessary information in order for the claim to be adjudicated within the timeframes described above.

2.18.5 Claims Reprocessing

If the Contractor or LDH or its subcontractors discover errors made by the Contractor when a claim was adjudicated, the Contractor shall make corrections and reprocess the claim within thirty (30) calendar days of discovery, or if circumstances exist that prevent the Contractor from meeting this time frame by a specified date subject to LDH approval. The Contractor shall automatically recycle all impacted claims for all providers and shall not require the provider to resubmit the impacted claims.

2.18.6 Adjustments and Voids

The Contractor may adjust or void incorrect claims payments in accordance with the **MCO Manual**.

2.18.7 Timely Filing Guidelines

2.18.7.1 The Contractor shall require providers to file Medicaid-only claims within three hundred sixty-five (365) calendar days of the date of service. Electronic submission of pharmacy claims (reversals and resubmittals) shall be allowed to process electronically within three hundred sixty-five (365) days of the date of service.

2.18.7.2 The Contractor shall require providers to file claims involving third party liability within three hundred sixty-five (365) calendar days from the date of service. The Contractor shall require Medicare claims to be submitted within six (6) months of Medicare adjudication.

2.18.7.3 The Contractor shall deny any claim not initially submitted by the three hundred and sixty-fifth (365^{th}) calendar day from the date of service, unless LDH, the Contractor or its subcontractors created the error.

2.18.7.4 The Contractor shall not deny claims submitted in cases of retroactive eligibility for timely filing if the claim is submitted within one hundred eighty (180) calendar days from the enrollee's linkage to the MCO.

2.18.8 Claim System Edits

2.18.8.1 The Contractor shall perform system edits including, but not limited to:

2.18.8.1.1 Confirming eligibility on each enrollee;

2.18.8.1.2 Validating enrollee name;

2.18.8.1.3 Validating unique enrollee identification number;

2.18.8.1.4 Validating date of service – Perform system edits for valid dates of service, and ensure that dates of services are valid dates such as not in the future or outside of an enrollee's Medicaid eligibility span;

2.18.8.1.5 Determination of medical necessity – By a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity;

2.18.8.1.6 Covered Services – Ensure that the system verifies that a service is a covered service and is eligible for payment;

2.18.8.1.7 Prior Authorization – The system shall determine whether a covered service required prior authorization and if so, whether the Contractor granted such authorization;

2.18.8.1.8 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;

2.18.8.1.9 Provider Validation – Ensure that the system shall approve for payment only those claims received from qualified providers eligible to render the service for which the claim was submitted and that the provider has not been excluded from receiving Medicaid payments as stipulated in the *Provider Network, Contracts, and Related Responsibilities* section; and

2.18.8.1.10 Quantity of Service – Ensure that the system shall evaluate claims for services provided to ensure that any applicable benefit limits are applied.

2.18.8.2 The Contractor shall perform post-payment review on a statistically valid sample of claims to ensure services provided were medically necessary.

2.18.8.3 The Contractor shall notify providers as to when system updates will be in production and of the Contractor's process for the recycling of denied claims that are due to system update delays. The recycling of these denied claims shall be completed no later than fifteen (15) calendar days after the system update.

2.18.8.4 Except as otherwise specified by LDH, the Contractor shall use only national standard code sets such as CPT/HCPCS, ICD-10-CM, etc. The Contractor shall also comply with deadlines for communication, testing and implementation of code sets established by CMS and/or LDH.

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

2.18.8.6 In addition to CPT, ICD-10-CM, ICD-10-PCS and other national coding standards, the Contractor shall use of applicable HCPCS Level II and Category II CPT codes to aid both the Contractor and LDH in evaluating performance measures.

2.18.8.7 The Contractor shall perform regular internal audit reviews to confirm claim edits are functioning properly and provide LDH with confirmation of this process. LDH shall be provided the results of internal audit reviews upon request.

2.18.8.8 The Contractor shall employ CMS mandated edits for Medicaid and nationally recognized clinical editing standards as outlined below:

2.18.8.8.1 At a minimum, these edits shall be maintained and updated annually unless otherwise appropriate and apply to practitioners, outpatient hospitals, and DME services.

2.18.8.8.2 Edits shall be based on current industry benchmarks and best practices including, but not limited to, specialty society criteria, American Medical Association CPT coding guidelines, and CMS mandated edits for Medicaid, which include the quarterly National Correct Coding Initiative (NCCI) edits or its successor.

2.18.8.8.3 These edits include, but are not limited to, units of service, unbundling, mutually exclusive and incidental procedures, pre/post-op surgical periods, modifier usage, multiple surgery reduction, add-on codes, cosmetic, and assistant surgeon. Editing shall include the ability to apply edits to the current claim as well as paid history claims when applicable.

2.18.8.8.4 The Contractor shall attest annually that they are adhering to these requirements and are subject to periodic requests from LDH for validation of the edits.

2.11.1.1 The Contractor shall update CMS mandated edits and NCCI edits quarterly as directed by CMS and adhere to LDH timelines for the updates.

2.18.9 Payment to Providers

2.18.9.1 At a minimum, the Contractor shall run one (1) provider payment cycle per week, on the same day each week.

2.18.9.2 The Contractor shall encourage that its providers, as an alternative to the filing of paper-based claims, submit and receive claims information through electronic data interchange (EDI).

2.18.9.3 The Contractor shall pay providers interest at a rate of twelve percent (12%) per annum, calculated daily for the full period in which a payable clean claim remains unpaid beyond the thirty (30) calendar day claims processing deadline. Interest owed to the provider shall be paid the same date that the claim is adjudicated, and reported on the encounter submission to the FI as defined in the **MCO Manual**.

2.18.9.4 The Contractor shall pay pharmacy providers no less than the LDH specified dispensing fee. In addition, any State imposed provider fees for pharmacy services shall be added on top of the minimum dispensing fee required by LDH.

2.18.10 Remittance Advices

In conjunction with its payment cycles, the Contractor shall provide that:

2.18.10.1 Each remittance advice generated by the Contractor to a provider shall comply with the provisions of La. R.S. 46:460.71.

2.18.10.2 Adjustments and Voids shall appear on the RA under "Adjusted or Voided Claims" either as Approved or Denied.

2.18.10.3 In accordance with 42 C.F.R. §455.18 and §455.19, the following statements shall be included on each remittance advice sent to providers:

2.18.10.3.1 "This is to certify that the foregoing information is true, accurate, and complete."

2.18.10.3.2 "I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws."

2.18.10.4 The Contractor shall submit a sample of remittance advices that were sent to independent, chain and specialty pharmacies by the PBM to LDH pharmacy staff quarterly. This sample shall include at least ten (10) RAs from each pharmacy type (independent, chain, and specialty).

2.18.11 Sampling of Paid Claims

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

2.18.11.1.1 Description of the service furnished;

2.18.11.1.2 The name of the provider furnishing the service;

2.18.11.1.3 The date on which the service was furnished;

2.18.11.1.4 The amount of the payment made for the service; and

2.18.11.1.5 The method for notifying the Contractor of services not rendered.

2.18.11.2 The Contractor shall stratify the paid claims sample to ensure that all provider types (or specialties) and all claim types are proportionally represented in the sample pool from the entire range of services available under the contract. To the extent that the

Contractor or LDH considers a particular specialty (or provider) to warrant closer scrutiny, the Contractor may over sample the group. The paid claims sample should be a minimum of two percent (2%) of paid claims per month to be reported on a quarterly basis.

2.18.11.3 The notices may be performed by mail, telephonically, or in person (e.g., case management on-site visits).

2.18.11.4 The Contractor shall track any responses received from enrollees and resolve the responses according to its established policies and procedures. The resolution may be enrollee education, provider education, payment recovery, or referral to LDH. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.

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

2.18.11.6 Reporting shall include, at a minimum, the total number of notices sent to enrollees, total number of responses completed, total services requested for validation, number of services validated, analysis of interventions related to resolution, and number of responses referred to LDH for further review.

2.18.12 Claims Dispute Management

2.18.12.1 The Contractor shall develop an internal claims dispute process for those claims or group of claims that have been denied or underpaid. The process shall be submitted as part of readiness reviews to LDH for approval.

2.18.12.2 The Contractor's Claims Dispute process shall allow providers the option to request binding arbitration for claims that have denied or underpaid claims or a group of claims bundled, by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the Contractor and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Section shall be binding on all parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) calendar days of being selected, unless the Contractor and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney fees, shall be shared equally by the parties.

2.18.12.3 The Contractor shall systematically capture the status and resolution of all claim disputes as well as all associated documentation.

2.18.12.4 The Contractor shall adjudicate all disputed claims to a paid or denied status within thirty (30) business days of receipt of the disputed claim.

2.18.12.5 The provider shall have one hundred and eighty (180) calendar days from the date of denial to dispute the denied claim.

2.18.13 Payment Recoupments

2.18.13.1 The Contractor shall provide written prior notification to a provider of its intent to recoup any payment.

2.18.13.2 The notification shall include:

2.18.13.2.1 The patient's name, date of birth, and Medicaid identification number;

2.18.13.2.2 The date(s) of health care services rendered;

2.18.13.2.3 A complete listing of the specific claims and amounts subject to the recoupment;

2.18.13.2.4 The specific reasons for making the recoupment for each of the claims subject to the recoupment;

2.18.13.2.5 The date the recoupment is proposed to be executed;

2.18.13.2.6 The mailing address or electronic mail address where a provider may submit a written response;

2.18.13.2.7 When applicable, the date LDH notified the Contractor of the enrollee's disenrollment via the ASC X12N 834 Benefit Enrollment and Maintenance Transaction; and

2.18.13.2.8 The effective date of disenrollment.

2.18.13.3 Before the recoupment is executed, the provider shall have forty-five (45) calendar days from receipt of written notification of recoupment to submit a written response to the Contractor as to why the recoupment should not be put into effect on the date specified in the notice. If the provider fails to submit a written response within the time period provided, the Contractor may execute the recoupment on the date specified in the notice.

2.18.13.4 Upon receipt by the Contractor of a written response as to why the recoupment should not be put into effect, the Contractor shall within thirty (30) calendar days from the date the written response is received, consider the statement, including any pertinent additional information submitted by the provider, together with any other material bearing upon the matter, and determine whether the facts justify recoupment. The Contractor shall provide a written notice of determination to each written response that includes the rationale for the determination.

2.18.13.5 If a recoupment is valid, the provider shall remit the amount to the Contractor or permit the Contractor to deduct the amount from future payments due to the provider.

2.18.13.6 LDH reserves the right to review and prohibit any recoupment.

2.18.13.7 For enrollees disenrolled due to the invalidation of a duplicate Medicaid ID, the Contractor shall not recover claim payments under the retroactively dis-enrolled member's ID if the remaining, valid ID is also linked to the same Contractor for the retroactive disenrollment period. The Contractor shall identify these duplicate Medicaid IDs for a single enrollee and resolve the duplication so that histories of the duplicate records are linked or merged.

2.18.13.8 The Contractor shall develop and implement a safeguard for automated reviews to prevent subsequent reviews on a claim when the denial or exception reason is the same as a previous denial or exception reason. The Contractor and its subcontractors shall not recover from a provider via automated review for a claim for which an automated denial was reversed subsequent to provider dispute, when the denials are for the same reason. For such claims, the Contractor shall ensure a complex review and consideration of the claim history or audit trail.

2.18.13.9 At the provider's request, the Contractor shall provide an independent review of claims that are the subject of an adverse determination by the Contractor. The review shall be provided and conducted in accordance with La. R.S. 46:460.81 through 460.90.

2.18.14 Claims Payment Accuracy Report

2.18.14.1 On a monthly basis, the Contractor shall submit a claims payment accuracy percentage report to LDH. The report shall be based on an audit conducted by the Contractor. The audit shall be conducted by an entity or staff independent of claims management, and shall utilize a randomly selected sample of all processed and paid claims upon initial submission in each month. A minimum sample consisting of two hundred (200) to two hundred-fifty (250) claims per month, based on financial stratification, shall be selected from the entire population of electronic and paper claims processed or paid upon initial submission.

2.18.14.2 The minimum attributes to be tested for each claim selected shall include:

2.18.14.2.1 Claim data is correctly entered into the claims processing system;

2.18.14.2.2 Claim is associated with the correct provider;

2.18.14.2.3 Proper authorization was obtained for the service;

2.18.14.2.4 Enrollee eligibility at processing date correctly applied;

2.18.14.2.5 Allowed payment amount agrees with contracted rate;

2.18.14.2.6 Duplicate payment of the same claim has not occurred;

2.18.14.2.7 Denial reason is applied appropriately;

2.18.14.2.8 Co-payments are considered and applied, if applicable;

2.18.14.2.9 Effect of modifier codes correctly applied; and

2.18.14.2.10 Proper coding.

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

2.18.14.3.1 Results for each attribute tested for each claim selected;

2.18.14.3.2 Amount of overpayment or underpayment for each claim processed or paid in error;

2.18.14.3.3 Explanation of the erroneous processing for each claim processed or paid in error;

2.18.14.3.4 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

2.18.14.3.5 Claims processed or paid in error have been corrected.

2.18.14.4 If the Contractor subcontracted for the provision of any covered services, and the subcontractor is responsible for processing claims, then the Contractor shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor.

2.18.15 Encounter Data

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

2.18.15.2 The Contractor shall create a unique Processor Control Number (PCN) or Group number for Louisiana Medicaid and shall submit the PCN or group number and the Bank Identification Number with the encounter claims data submission.

2.18.15.3 For encounter data submissions, the Contractor shall:

2.18.15.3.1 Submit complete and accurate encounter data at least monthly to LDH or its FI, as directed by LDH; and

2.18.15.3.2 Submit 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 Contractor or its subcontractor has a capitation arrangement with a provider. If the Contractor fails to submit complete encounter data, including encounters processed by vendors, as measured by a comparison of encounters to cash disbursements within a one percent (1%) error threshold (i.e., encounters are at least ninety-nine percent (99%) but no greater than one hundred percent (100%) of cash

disbursements), LDH may impose monetary penalties in accordance with Attachment E, *Table of Monetary Penalties*.

2.18.15.4 The Contractor shall submit HIPAA compliant 837 encounters for Institutional, Professional and Dental, and the NCPDP D.0 format in a batch processing method for pharmacy encounters. The Contractor shall be able to transmit this encounter data to the FI thirty (30) calendar days after the operational start date. Inpatient Hospital services (Institutional encounters indicating Facility Type Code of 11, 12, 18, 21 or 86) are adjudicated at the document level. All other encounters are adjudicated at the line level.

2.18.15.5 As part of the readiness reviews, the Contractor's system shall be ready to submit encounter data to the FI according to specifications, including data elements and reporting requirements, in the **MCO Manual**. The Contractor's system shall submit such encounter data within thirty (30) calendar days of the operational start date. The Contractor shall incur all costs associated with certifying HIPAA transactions readiness through a third party prior to submitting encounter data to the FI.

2.18.15.6 The Contractor shall provide the FI with complete and accurate encounter data for all levels of health care services provided, including all claims paid, denied, adjusted or voided directly by the Contractor or indirectly through a subcontractor.

2.18.15.7 The Contractor shall have the capability to convert all information that enters its claims system via hard copy paper claims to electronic encounter data, for submission in the appropriate HIPAA compliant formats to LDH's FI.

2.18.15.8 The Contractor shall ensure that all encounter data from a subcontractor is incorporated into files submitted by the Contractor to the FI. The Contractor shall not submit separate encounter files from subcontractors.

2.18.15.9 The Contractor shall ensure the level of detail associated with encounters from providers with whom the Contractor has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the Contractor received and settled a fee-for-service claim.

2.18.15.10 The Contractor shall utilize the **MCO Manual** and become familiar with the claims data elements that shall be included in encounters. The Contractor 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.

2.18.15.11 The Contractor 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 across all MCOs.

2.18.15.12 The Contractor shall submit paid, denied, adjusted, and voided claims as encounters to the FI. LDH shall establish the appropriate identifiers to indicate these claims as encounters, as provided in the **MCO Manual**.

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

2.18.15.14 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 a batch submission by the Contractor. Any submission which contains fatal errors that prevent processing, or that does not satisfy defined threshold error rates, shall be rejected and returned to the Contractor for correction and resubmission to the FI in the next payment cycle.

2.18.15.15 LDH has authorized its FI to edit MCO encounters using a common set of edit criteria, that might cause denials, and MCOs should resolve denied encounters when appropriate. Encounter denial codes shall be deemed "repairable" or "non-repairable". The Contractor is required to be familiar with the FI edit codes and dispositions for the purpose of repairing encounters denied by the FI. A list of encounter edit codes is located in the **MCO Manual.**

2.18.15.16 In order to maintain integrity of processing, the Contractor shall address any issues that prevent processing of an encounter. Acceptable standards shall be ninety percent (90%) of reported repairable errors are addressed within thirty (30) calendar days and ninety-nine percent (99%) of reported repairable errors within sixty (60) calendar days or within a negotiated timeframe approved by 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.

2.18.15.17 The Contractor CEO, CFO or their designee shall attest to the truthfulness, accuracy, and completeness of all encounter data submitted.

2.18.15.18 The Contractor shall make an adjustment to encounter claims when the Contractor 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. Incorrect provider numbers, incorrect enrollee Medicaid ID numbers, or incorrect claim types cannot be adjusted. The encounter record must be voided and re submitted as an original. All other adjustments to an encounter record shall be done as an adjustment record.

2.18.15.19 If LDH or its subcontractors discover errors or a conflict with a previously adjudicated encounter claim, the Contractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH, or if circumstances exist that prevent contractor from meeting this time frame, by a specified date approved by LDH. The Contractor shall obtain prior approval from LDH for any submission to LDH's Fiscal Intermediary for numbers greater than one hundred thousand (100,000) encounter claims.

2.18.16 Claims Summary Report

The Contractor shall submit monthly Claims Summary Reports of paid and denied claims to LDH by claim type. Instructions are provided in the **MCO Manual**.

2.18.17 Pharmacy Claims Processing

2.18.17.1 System Requirements

2.18.17.1.1 The Contractor shall have an automated claims and encounter processing system for pharmacy claims that will support the requirements of this contract and ensure the accurate and timely processing of claims and encounters. The Contractor shall allow pharmacies to back bill electronically (reversals and resubmissions) for three hundred sixty-five (365) calendar days from the date of the original submission of the claim.

2.18.17.1.2 The Contractor shall support electronic submission of claims using the most current HIPAA compliant transaction standard (currently NCPDP D.0).

2.18.17.1.3 Pharmacy claim edits shall include eligibility, drug coverage, benefit limitations, prescriber and prospective/concurrent drug utilization review edits.

2.18.17.1.4 The system shall provide for an automated update to the National Drug Code file including all product, packaging, prescription and pricing information. The system shall provide online access to reference file information. The system should maintain a history of the pricing schedules and other significant reference data. The drug file for both retail and specialty drugs, including price, shall be updated at a minimum every seven (7) calendar days or more frequently, at the Contractor's discretion.

2.18.17.1.5 The Contractor shall comply with the claims history requirements in this Section.

2.18.17.1.6 The Contractor shall ensure that the manufacturer number, product number, and package number for the drug dispensed shall be listed on all claims. This information shall be taken from the actual package from which the drug is usually purchased by a provider, from a supplier whose products are generally available to all pharmacies and reported in one or more national compendia.

2.18.17.1.7 Provisions shall be made to maintain permanent history by service date for those services identified as "once-in-a-lifetime."

2.18.17.2 Pharmacy Rebates

The Contractor shall submit all drug encounters, with the exception of inpatient hospital drug encounters, to LDH or its contractor pursuant to the requirements of this section. LDH or its subcontractor shall submit these encounters for federal or supplemental pharmacy rebates from manufacturers under the authority of the LDH

Secretary pursuant to the Section 2501 of the Patient Protection and Affordable Care Act (ACA).

2.18.17.3 Pharmacy Encounters Claims Submission

2.18.17.3.1 The Contractor shall submit a weekly claim-level detail file of pharmacy encounters to LDH which includes individual claim-level detail information on each pharmacy claim dispensed to a Medicaid patient including, but not limited to, the total number of metric units, dosage form, strength and package size, and National Drug Code of each covered outpatient drug dispensed to Medicaid enrollees. This weekly submission must comply with encounter data requirements of this section. See the **MCO Manual** for a complete listing of claim fields required.

2.18.17.3.2 At the request of LDH or its Fiscal Intermediary, the Contractor shall submit pharmacy claims information in an electronic format that is suited to allow for integration with the State's pharmacy rebate program according to the schedule established by LDH. The pharmacy rebate process is a quarterly process and claims information is usually required before the end of the month that follows the end of the quarter.

2.18.17.3.3 The Contractor shall require that network providers who are covered entities, as defined by Section 340B of the Public Health Services Act, utilize the same carve-in or carve-out designation for the MCO's enrollees as for FFS Medicaid beneficiaries. If a covered entity appears on the Medicaid Exclusion File, LDH will exclude that provider's FFS and MCO claims from rebate invoicing. Claims for FFS Medicaid and Medicaid managed care beneficiaries are treated identically in regards to exclusion from rebate invoicing.

2.18.17.3.4 The Contractor shall utilize a unique Processor Control Number (PCN) or Group Number for Louisiana Medicaid. This unique PCN or group number shall be submitted to LDH before processing any pharmacy claims.

2.18.17.3.5 Contract pharmacies are not permitted to bill Medicaid for drugs purchased at 340B pricing. This includes both FFS and Medicaid managed care.

2.18.17.3.6 The Contractor shall include billing instructions on how to identify 340B claims/encounters in their contracts with 340B providers.

2.18.17.4 Disputed Pharmacy Encounter Submissions

2.18.17.4.1 On a weekly basis, LDH shall review the Contractor's pharmacy encounter claims and send a file back to the Contractor of disputed encounters that were identified through the drug rebate invoicing process.

2.18.17.4.2 Within sixty (60) calendar days of receipt of the disputed encounter file from LDH, the Contractor shall, if needed, correct and resubmit any disputed encounters and send a response file that includes 1) corrected and resubmitted encounters as described in the Rebate Section of the **MCO**

Manual, and/or 2) a detailed explanation of why the disputed encounters could not be corrected including documentation of all attempts to correct the disputed encounters at an encounter claim level detail, as described in the Rebate Section of the **MCO Manual**.

2.18.17.4.3 The Contractor may be subject to monetary penalties in accordance with Attachment E for failure to submit weekly pharmacy encounter claims files and/or a response file to the disputed encounters file within sixty (60) calendar days as detailed above for each disputed encounter.

2.18.17.5 Use of a Pharmacy Benefits Manager (PBM)

If the Contractor utilizes a PBM for pharmacy claims payment and administrative services, then the following requirements shall apply:

2.18.17.5.1 The Contractor shall identify the proposed PBM and the ownership of the proposed PBM. Before entering into a subcontract with a PBM, the Contractor shall obtain written approval by LDH. The Contractor shall submit a written description of the assurances and procedures that shall be put in place under the proposed PBM subcontract, such as an independent audit, to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information. The Contractor shall provide a plan documenting how it will monitor such PBM. These assurances and procedures shall be transmitted to LDH for review and approval prior to the date pharmacy services begin;

2.18.17.5.2 The Contractor shall submit a plan for oversight of the PBM's performance prior to the implementation of the Contractor's PBM. The plan shall be subject to LDH approval and comply with this Contract and all LDH requirements; and

2.18.17.5.3 The Contractor PBM shall not deny any Louisiana licensed pharmacy or Louisiana licensed pharmacist the right to be a participating provider in the Contractor or PBM provider network if the pharmacy or pharmacist meets all requirements of participation in the Louisiana Medicaid program.

2.18.17.5.4 Any contract for pharmacy benefits manager services shall:

2.18.17.5.4.1 Be limited to a transaction fee, not to exceed $1.25 per paid claim. The transaction fee covers non-claims costs, exclusive of amounts paid to a pharmacy for a prescription, including the ingredient cost, dispensing fee and provider fee;

2.18.17.5.4.2 Exclude any rebates or discounts, direct or indirect, from any pharmaceutical manufacturer; and

2.18.17.5.4.3 Exclude "spread pricing," defined as any amount charged or claimed by a pharmacy benefits manager to a managed care organization that

is in excess of the amount paid to the pharmacy for a prescription, including the ingredient cost, provider fee and dispensing fee.

2.18.17.6 With one-hundred eighty (180) calendar days of written notice to the Contractor, LDH may require the Contractor to contract with a PBM selected by LDH through a competitive procurement contract. LDH has the sole discretion to establish the contract terms.

2.18.17.7 With ninety (90) calendar days of written notice to the Contractor, LDH may carve out all outpatient pharmacy services from managed care.

2.18.18 Audit Requirements

The Contractor shall ensure that its 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.

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

2.18.18.1 State Audits

2.18.18.1.1 The Contractor shall provide to State auditors (including legislative auditors), or their designee, upon written request, files for any specified accounting period that a valid Contract exists in a file format or audit defined media, magnetic tapes, CD or other media compatible with LDH and/or State auditor's facilities. The Contractor shall provide information necessary to assist the State auditor in processing or utilizing the files.

2.18.18.1.2 If the auditor's findings point to discrepancies or errors, the Contractor shall provide a written corrective action plan to LDH within ten (10) business days of receipt of the final audit report.

2.18.18.2 Louisiana Legislative Auditor Authority

2.18.18.2.1 The Contractor shall enter into a data sharing agreement (DSA) with the Louisiana Legislative Auditor (LLA) to authorize the sharing of data and information.

2.18.18.2.2 The Contractor agrees and acknowledges that the LLA has the authority pursuant to La. R.S. 24:51 et seq., subject to state and federal laws and privileges protecting the confidentiality of information, to conduct oversight and audit of LDH, including the Medicaid managed care program. Pursuant to the DSA, LLA may, in coordination with LDH and the Contractor:

2.18.18.2.2.1 Attend quarterly meetings between the Contractor, LDH, and the DOJ MFCU;

2.18.18.2.2.2 Evaluate the effectiveness of the Contractor's program integrity outcomes;

2.18.18.2.2.3 Audit, evaluate and inspect the books, records, and contracts related to the performance of the Contractor; and

2.18.18.2.2.4 Access all audit information relating to the performance of the Contractor obtained by LDH related to the Medicaid managed care program.

2.18.18.2.3 Contemporaneous with the execution of any emergency contract, the DSA shall be amended to extend its term to coincide with the term of the emergency contract.

2.18.18.3 Independent Audits of Systems

2.18.18.3.1 The Contractor shall submit an independent SOC 2 Type II system audit. The audit shall 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 Contractor's fiscal year, with no breaks between subsequent audit periods.

2.18.18.3.2 The Contractor 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 Contractor's fiscal year.

2.18.18.3.3 The Contractor shall deliver to LDH a corrective action plan to address deficiencies identified during the audit within thirty (30) business days of the Contractor's receipt of the final audit report.

2.18.18.3.4 These audit requirements are also applicable to any subcontractors or vendors delegated the responsibility of adjudicating claims on behalf of the Contractor. The cost of the audit shall be borne by the Contractor or subcontractor.

2.18.18.4 Audit Coordination and Claims Reviews

2.18.18.4.1 The Contractor shall coordinate audits with LDH as directed by LDH.

2.18.18.4.2 LDH reserves the right to review any claim paid by the Contractor or designee. The Contractor has the right to collect or recoup any overpayments identified by the Contractor 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 Contractor to collect and remit the overpayment to LDH. Failure by the

Contractor to collect from the provider does not relieve the Contractor from remitting the identified overpayment to LDH.

2.18.18.4.3 The Contractor must complete all audits of a provider claim no later than one (1) year after receipt of a clean claim, regardless of whether the provider participates in the Contractor's network. This includes an "automated" review, which is one for which an analysis of the paid claim 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.

2.18.18.4.3.1 This limitation does not apply in cases of provider fraud, waste, or abuse that the Contractor did not discover within the one (1)-year period following receipt of a claim via "complex" review. (Additional information regarding automated and complex reviews may be found in the *Fraud, Waste and Abuse Prevention* section.)

2.18.18.4.3.2 This limitation also does not apply when CMS, the Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, the Government Accountability Office (GAO), LDH, and/or any of their designees conclude an examination, audit, or inspection of a provider more than one (1) year after the Contractor received the claim.

2.18.19 LaHIPP

The Louisiana Health Insurance Premium Payment (LaHIPP) program is a Louisiana Medicaid program that pays all or part of the health insurance premium for an employee and their family if: (a) health insurance is available from their job (i.e., Employer Sponsored Insurance); (b) someone in the family has Medicaid; and (c) it is determined that it would cost less for Louisiana Medicaid to pay the health insurance premium for the person who receives Medicaid than it would be for Louisiana Medicaid to pay the cost of the same person's per member per month payment for physical health coverage through the enrollee's managed care organization. The goal of LaHIPP is to reduce the number of the uninsured Louisiana citizens and lower Medicaid spending by establishing a third party resource as the primary payer of the Medicaid enrollee's medical expenses.

LDH is responsible for determining if an individual qualifies for LaHIPP participation. LaHIPP is not an eligibility category. LaHIPP participants are identified in the TPL file.

LDH is responsible for issuing payment for all or part of LaHIPP participants' health insurance premium.

2.18.19.1 The Contractor is responsible for payment of LaHIPP participants' total member liability (co-payments, co-insurance and deductibles) if the participant uses a provider that accepts the insurance as primary payer and Medicaid as secondary payer. If the provider does not accept this payment arrangement, the participant shall be responsible for the member liability. The Contractor pays only after the third party

has met the legal obligation to pay. The Contractor is always the payer of last resort, except when the Contractor is responsible for payment as primary payer for mental health services and transportation services not covered by commercial insurance as primary payer.

2.18.19.2 The mental health services listed below are typically not reimbursed by commercial health plans. The Contractor shall accept the following claims billed directly from the mental health provider without requiring an explanation of benefits from the primary carrier and pay as primary payer:

- H2013-Psychiatric Residential Treatment Facility
- H0018-Therapeutic Group Home
- H0039-Assertive Community Treatment per diem
- H0045-Crisis Stabilization
- H2017-Psychosocial Rehabilitation Services
- H0036-Community psychiatric support and treatment
- H2033-Multi-systemic Therapy
- H2011-Crisis Intervention Service, per 15 minutes
- S9485-Crisis Intervention Mental Health Services

2.19 Systems and Technical Requirements

2.19.1 General Requirements

2.19.1.1 The Contractor shall maintain an automated Management Information System (MIS), hereinafter referred to as System, which accepts and processes provider claims, verifies eligibility, collects and reports encounter data, and validates prior authorization and pre-certification that complies with LDH and federal reporting requirements. The Contractor shall ensure that its System meets the requirements of the Contract, the **MCO Manual**, and all applicable state and federal laws, rules and regulations, including Medicaid confidentiality and HIPAA and American Recovery and Reinvestment Act (ARRA) privacy and security requirements.

2.19.1.2 The System shall provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility [42 C.F.R. §438.242(a)].

2.19.1.3 The Contractor shall comply with Section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval

systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Act [42 C.F.R. §438.242(b)(1); Section 6504(a) of the ACA; Section 1903(r)(1)(F) of the Act].

2.19.1.4 The MCO application systems foundation shall employ a relational data model in its database architecture, which would entail the utilization of a relational database management system (RDBMS). It is important that the MCO's application systems support query access using Structured Query Language (SQL). Other standard connector technologies, such as Open Database Connectivity (ODBC) and/or Object Linking and Embedding (OLE), are desirable.

2.19.1.5 The Contractor shall comply with the health IT standards referenced in 45 C.F.R. Part 170, Subpart B and the Interoperability Standards Advisory (ISA) as set forth by the Office of the National Coordinator for Health IT (ONC).

2.19.1.6 All MCO applications, operating software, middleware, and networking hardware and software shall be able to interoperate as needed with LDH's systems and shall conform to applicable standards and specifications set by LDH.

2.19.1.7 If the Contractor uses different Management Systems for physical health services and behavioral health services, these systems shall be interoperable. In addition, the Contractor shall have the capability to integrate data from the different systems.

2.19.1.8 The Contractor's System shall have, and maintain, capacity sufficient to handle the workload projected for the begin date of operations and shall be scalable and flexible so that it can be adapted as needed, within negotiated timeframes, in response to changes in the Contract requirements.

2.19.1.9 The Contractor shall be capable of transmitting 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 shall be transmitted via Secure File Transfer Protocol (SFTP) to LDH. Any other data or method of transmission used for this purpose shall be via written agreement by both parties.

2.19.1.10 The Contractor is responsible for procuring and maintaining hardware and software resources which are sufficient to successfully perform the services detailed in this Contract.

2.19.1.11 The Contractor shall adhere to state and federal regulations and guidelines as well as industry standards and best practices for systems or functions required to support the requirements of this Contract.

2.19.1.12 Unless explicitly stated to the contrary, the Contractor is responsible for all expenses required to obtain access to LDH systems—including systems maintained by other Contractors including, but not limited to, Medicaid fiscal intermediary and Medicaid enrollment broker resources which are relevant to successful completion of the

requirements of this Contract. The Contractor is also responsible for expenses required for LDH to obtain access to the Contractor's systems or resources which are relevant to the successful completion of the requirements of this Contract. Such expenses are inclusive of hardware, software, network infrastructure and any licensing costs.

2.19.1.13 MCO interface connections with the State shall be established, monitored, and maintained in compliance with the State's Information Security Policy located at: http://www.doa.la.gov/pages/ots/informationsecurity.aspx.

2.19.1.14 The Contractor or its designated subcontractor shall take all steps necessary, as determined by LDH, to ensure that the Contractor's systems are always able to interface with LDH IT applications.

2.19.1.15 Any confidential information shall be encrypted to FIPS 140-2 standards when at rest or in transit.

2.19.1.16 Contractor owned resources shall 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).

2.19.1.17 Any Contractor use of flash drives or external hard drives for storage of Medicaid data shall first receive written approval from LDH and upon such approval shall adhere to FIPS 140-2 hardware level encryption standards.

2.19.1.18 All Contractor utilized computers and devices shall:

2.19.1.18.1 Be protected by industry standard virus protection software which is automatically updated on a regular schedule;

2.19.1.18.2 Have installed all security patches which are relevant to the applicable operating system and any other system software; and

2.19.1.18.3 Have encryption protection enabled at the Operating System level.

2.19.1.19 The Contractor shall have:

2.19.1.19.1 Capabilities of interagency electronic transfer to and from the participating State agencies (LDH-OBH, DCFS, and OJJ) as needed to support the operations as determined by LDH;

2.19.1.19.2 Electronic storage and retrieval of individualized Plans of Care (POC), treatment plans, crisis plans, and advance directives;

2.19.1.19.3 An MCO Data Warehouse that supports the timely submission of valid data, including, but not limited to, encounter data;

2.19.1.19.4 A secure online web-based portal that allows providers and state agencies (DCFS, LDOE, LDH, and OJJ) to submit and receive responses to referrals and prior authorizations for services; and

2.19.1.19.5 An MIS that regularly (e.g., bi-weekly) electronically transfers client/episode-level recipient, assessment, service, and provider data as directed by LDH for purposes of state and federal reporting (e.g., SAMHSA National Outcome Measures (NOMS), Treatment Episode Data Sets (TEDS), Government Performance Reporting and Results Act (GPRA)), and for ad hoc reporting as needed by the State for service quality monitoring and performance accountability.

2.19.2 HIPAA Standards and Code Sets

2.19.2.1 The System shall be able to transmit, receive and process data in current HIPAA-compliant or LDH specific formats and/or methods, including, but not limited to, secure File Transfer Protocol (FTP) over a secure connection such as a Virtual Private Network (VPN), that are in use at the start of Systems readiness review activities. Data elements and file format requirements may be found in the **MCO Manual**.

2.19.2.2 All HIPAA-conforming exchanges of data between LDH, its contractors, and the MCO shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker. The HIPAA Business Associate Addendum (Attachment H) shall become a part of the Contract.

2.19.2.3 The System shall conform to the following HIPAA-compliant standards for information exchange. Batch transaction types include, but are not limited to, the following:

- ASC X12N 834 Benefit Enrollment and Maintenance;
- ASC X12N 835 Claims Payment Remittance Advice Transaction;
- ASC X12N 837I Institutional Claim/Encounter Transaction;
- ASC X12N 837P Professional Claim/Encounter Transaction;
- ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;
- ASC X12N 276 Claims Status Inquiry;
- ASC X12N 277 Claims Status Response;
- ASC X12N 278 Utilization Review Inquiry/Response;
- ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products; and

- NCPDP Pharmacy Claims.

2.19.2.4 The Contractor shall not revise or modify standardized forms or formats.

2.19.2.5 Transaction types are subject to change and the Contractor shall comply with applicable Federal and HIPAA standards and regulations as they occur.

2.19.2.6 The Contractor shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with LDH. These shall include, but not be limited to, HIPAA based standards and Federal safeguard requirements including signature requirements described in the **CMS State Medicaid Manual**.

2.19.3 Connectivity

2.19.3.1 LDH is requiring that the MCO interface with LDH, the Medicaid Fiscal Intermediary (FI), the enrollment broker (EB), and its trading partners. The Contractor shall have capacity for real time connectivity to all LDH approved systems. The Contractor shall have the capability to allow and enable authorized LDH personnel to have real-time connectivity to the MCO's system as remote connections from LDH offices.

2.19.3.2 The System shall conform and adhere to the data and document management standards of LDH and its FI, inclusive of standard transaction code sets as outlined in the **MCO Manual**.

2.19.3.3 The MCO's Systems shall utilize mailing address standards in accordance with the United States Postal Service.

2.19.3.4 The Contractor shall encourage all hospitals, physicians, and other providers in its network to adopt certified electronic health record technology (CEHRT) and comply and attest with its corresponding meaningful use requirements and deadlines as outlined by CMS and the Office of the National Coordinator (ONC).

2.19.3.5 The Contractor shall require all emergency departments (EDs) in its network to exchange admit discharge transfer (ADT) data with a Health Information Exchange (HIE) ED visit registry to aid in identification of and creation of policies around high utilizers, drug seeking behavior, and chronic disease management. The visit registry shall consist of three (3) basic attributes: 1) the ability to capture and match patients based on demographics information, 2) the ability to identify the facility at which care is being sought, and 3) at minimum, the chief complaint of the visit. These three (3) pieces of information are commonly available through the Health Level Seven (HL7) ADT message standard and in use by most ED admission systems in use today across the country. This data shall be available in real-time in order to assist providers and systems with up-to-date information for treating patients appropriately.

2.19.3.6 The Contractor shall require all network hospitals to comply with the data submission requirements of La R.S. 40:1173.1 through 1173.6. Including, but not limited to, syndromic surveillance data under the Sanitary Code of the State of Louisiana (LAC

51:II.105). The MCO shall encourage the use of HIEs where direct connections to public health reporting information systems are not feasible or are cost prohibitive.

2.19.3.7 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 Contractor 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.

2.19.3.8 The Medicaid Management Information System (MMIS) processes claims and payments for covered Medicaid services within the FFS Medicaid program. LDH shall require the Contractor to comply with all transitional requirements as necessary if LDH contracts with a new FI during the Contract term at no cost to LDH or its FI.

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

2.19.3.10 LDH may require the Contractor to complete an Information Systems Capabilities Assessment (ISCA), which shall be provided by LDH. If required by LDH, the ISCA shall be completed and returned to LDH as part of readiness reviews.

2.19.4 Hardware and Software

The Contractor shall maintain hardware and software compatible with current LDH requirements in accordance with the **MCO Manual**.

2.19.5 Network and Back-up Capabilities

The Contractor shall have network and back-up capabilities in accordance with the **MCO Manual**.

2.19.6 Resource Availability and Systems Changes

2.19.6.1 Resource Availability

The Contractor shall provide Systems Help Desk services to LDH, its FI, and enrollment broker staff that have direct access to the data in the MCO's Systems.

2.19.6.1.1 The Systems Help Desk shall:

2.19.6.1.1.1 Be available via local and toll-free telephone service, and via e-mail from 7:00 a.m. to 7:00 p.m., Central Time, Monday through Friday, with the exception of state holidays. Upon request by LDH, the Contractor shall be required to staff the Systems Help Desk on a state holiday, Saturday, or Sunday;

2.19.6.1.1.2 Answer questions regarding the MCO's System functions and capabilities; report recurring programmatic and operation problems to appropriate staff for follow-up; redirect problems or queries that are not supported by the Systems Help Desk, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate LDH staff;

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

2.19.6.1.1.4 Ensure recurring problems not specific to Systems unavailability identified by the Systems Help Desk are documented and reported to MCO management within one (1) business day of recognition so that deficiencies are promptly corrected; and

2.19.6.1.1.5 Have an IS service management system that provides an automated method to record, track and report all questions and/or problems reported to the Systems Help Desk.

2.19.6.2 Systems Quality Assurance Plan

The Contractor shall ensure that written Systems process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems. The Systems Quality Assurance Plan information systems documentation requirements must be submitted to LDH as part of readiness reviews for approval. At a minimum, the Systems Quality Assurance Plan must address the following:

2.19.6.2.1 The Contractor 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.

2.19.6.2.2 The Contractor shall ensure the Systems user manuals contain information about, and instruction for, using applicable Systems functions and accessing applicable system data.

2.19.6.2.3 The Contractor shall ensure when a System change is subject to LDH prior written approval, the Contractor will submit revision to the appropriate manuals before implementing said Systems changes.

2.19.6.2.4 The Contractor shall ensure all aforementioned manuals and reference guides are available in printed form and online; and

2.19.6.2.5 The Contractor shall update the electronic version of these manuals immediately, and update printed versions within ten (10) business days of the update taking effect.

2.19.6.2.6 The Contractor shall provide to LDH documentation describing its Systems Quality Assurance Plan.

2.19.6.3 Systems Changes

2.19.6.3.1 The MCO's Systems shall conform to future federal and/or LDH specific standards for encounter data exchange prior to the standard's effective date, unless otherwise directed by CMS or LDH.

2.19.6.3.2 If a system update and/or change is necessary, the Contractor shall draft appropriate revisions for the documentation or manuals, and present 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.

2.19.6.3.3 The Contractor shall notify LDH staff of the following changes to its System within its span of control at least ninety (90) calendar days prior to the projected date of the change, unless otherwise directed by LDH:

2.19.6.3.3.1 Major changes, upgrades, modification or updates to application or operating software associated with the following core production Systems:

- Claims processing;
- Eligibility and enrollment processing;
- Service authorization management;
- Provider enrollment and data management; and
- Conversions of core transaction management Systems.

2.19.6.3.4 The Contractor shall respond to LDH notification of System problems not resulting in System unavailability according to the following timeframes:

2.19.6.3.4.1 Within five (5) calendar days of receiving notification from LDH, the Contractor shall respond in writing to notices of system problems.

2.19.6.3.4.2 Within fifteen (15) calendar days, the correction shall be made or a requirements analysis and specifications document will be due.

2.19.6.3.4.3 The Contractor shall correct the deficiency by an effective date to be determined by LDH.

2.19.6.3.4.4 The Contractor's Systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.

2.19.6.3.4.5 The Contractor shall put in place procedures and measures for safeguarding against unauthorized modification to the Contractor's Systems.

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

2.19.6.3.6 The Contractor 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 Contractor's System.

2.19.7 Systems Refresh Plan

2.19.7.1 The Contractor shall provide to LDH a Systems Refresh Plan as part of readiness reviews and sixty (60) days prior to implementation of revisions. The plan shall outline how Systems within the Contractor's span of control shall 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.

2.19.7.2 The systems refresh plan shall also indicate how the Contractor shall ensure that the version and/or release level of all of its Systems components (application software, operating hardware, and 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.

2.19.8 Other Electronic Data Exchange

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

2.19.8.2 The Contractor shall implement Optical Character Recognition (OCR) technology that minimizes manual indexing and automates the retrieval of scanned documents.

2.19.9 Electronic Messaging

2.19.9.1 The Contractor shall provide a continuously available electronic mail communication link (e-mail system) to facilitate communication with LDH. This e-mail system shall be capable of attaching and sending documents created using software compatible with LDH's installed version of Microsoft Office (currently 2016) and any subsequent upgrades as adopted. The e-mail system shall also be capable of sending e-mail blasts to providers.

2.19.9.2 As needed, the Contractor shall be able to communicate with LDH over a secure Virtual Private Network (VPN).

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

2.19.10 Eligibility and Enrollment Data Exchange

The Contractor shall:

2.19.10.1 Receive, process and update enrollment files sent by the enrollment broker, and update eligibility and enrollment databases within the following timelines:

2.19.10.1.1 Daily files – within twenty-four (24) hours of receipt;

2.19.10.1.2 Weekly reconciliation files – within three (3) business days of receipt;

2.19.10.1.3 Quarterly or monthly reconciliation files – within five (5) business days of receipt; and

2.19.10.1.4 Special corrections files – within seven (7) business days of receipt;

2.19.10.2 Be capable of uniquely identifying (i.e., Master Patient Index) a distinct Medicaid enrollee across multiple populations and Systems within its span of control; and

2.19.10.3 Be able to identify potential duplicate records for a single enrollee and, upon confirmation of said duplicate record by LDH, resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

2.19.11 Provider Enrollment

2.19.11.1 At the onset of the Contract and periodically as changes are necessary, LDH shall furnish to the Contractor a list of Louisiana Medicaid provider types, specialty, and sub-specialty codes. In order to coordinate provider enrollment records, the Contractor shall utilize the published list of Louisiana Medicaid provider types,

specialty, and sub-specialty codes in all provider data communications with LDH and the enrollment broker. The Contractor shall provide the following:

2.19.11.1.1 A weekly Provider Registry File as described in the **MCO Manual**;

2.19.11.1.2 A weekly Primary Care Provider Linkage file as described in the **MCO Manual**; and

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

2.19.12 Information Systems Availability

The Contractor shall:

2.19.12.1 Not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the Contractor's span of control;

2.19.12.2 Allow LDH personnel, agents of the Louisiana Attorney General's Office, individuals authorized by LDH, and CMS direct, real-time, read-only access to its data for the purpose of data mining and review. Access shall be granted within thirty (30) calendar days of LDH request. Direct, real-time, read-only access can be provided through a SQL based production-like reporting environment to be updated no less than weekly with the ability to query using Microsoft SQL Server Management Studio©, or similar enterprise-grade technology which shall be subject to LDH approval. This reporting environment shall include all data from the systems referenced in the Contract or any additional data upon LDH request. Alternatively, the Contractor may provide data directly to LDH in a standardized format and layout to be developed by LDH that will be updated no less than weekly containing data from the systems referenced in the Contract or any additional data upon LDH request.

2.19.12.2.1 Access shall be provided to the following Contractor (including subcontractors) systems (this is not an exclusive list):

2.19.12.2.1.1 Prior authorization;

2.19.12.2.1.2 Claims processing;

2.19.12.2.1.3 Provider portal;

2.19.12.2.1.4 Third party liability;

2.19.12.2.1.5 Fraud, waste, and abuse;

2.19.12.2.1.6 Pharmacy benefits manager point of sale;

2.19.12.2.1.7 Pharmacy benefits manager prior authorization; and

2.19.12.2.1.8 Provider contracting and credentialing.

2.19.12.2.2 The Contractor's satisfaction of the requirements to provide the direct, real-time access to LDH personnel shall not constitute constructive compliance with nor relieve the Contractor of any duty to satisfy any other provision of this Contract, including, but not limited to, the Contractor's obligation to provide information at the request of LDH.

2.19.12.3 Provide training of LDH staff on how to use the Contractor's Systems and data on-site at the Contractor's location upon request by LDH;

2.19.12.4 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 Contractor. Unavailability caused by events outside of the Contractor's span of control is outside of the scope of this requirement;

2.19.12.5 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;

2.19.12.6 Ensure that the systems and processes within its span of control associated with its data exchanges with LDH's FI and/or enrollment broker and its contractors are available and operational;

2.19.12.7 Ensure that in the event of a declared major failure or disaster, the Contractor's core eligibility/enrollment and claims processing system shall be back on line within seventy-two (72) hours of the failure's or disaster's occurrence;

2.19.12.8 Notify designated LDH staff via phone, fax and/or electronic mail within sixty (60) minutes of discovery of a problem within or outside the Contractor'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 Contractor and LDH or LDH's FI. In its notification, the Contractor shall explain in detail the impact to critical path processes such as enrollment management and encounter submission processes;

2.19.12.9 Notify designated LDH staff via phone, fax, and/or electronic mail within fifteen (15) minutes of 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;

2.19.12.10 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;

2.19.12.11 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 Contractor's span of control. Unscheduled System unavailability to all other System functions caused by system and telecommunications technologies within the Contractor's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability;

2.19.12.12 Cumulative Systems unavailability caused by systems and/or IS infrastructure technologies within the Contractor's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period; and

2.19.12.13 Within five (5) business days of the occurrence of a problem with system availability, the Contractor shall provide LDH with full written documentation that includes a corrective action plan describing how the Contractor shall prevent the problem from reoccurring.

2.19.13 Contingency Plan

2.19.13.1 The Contractor, 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) and to continue essential application or system functions during or immediately following failures or disasters.

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

2.19.13.3 The Contractor shall have a Contingency Plan that shall be submitted to LDH as part of readiness reviews for approval.

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

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

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

2.19.13.4.3 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;

2.19.13.4.4 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

2.19.13.4.5 The Plan shall specify projected recovery times and data loss for mission-critical Systems in the event of a declared disaster.

2.19.13.5 The Contractor shall annually test its plan through simulated disasters and lower level failures in order to demonstrate to LDH that it can restore Systems functions. The Contractor shall report documentation of this testing in a manner determined by LDH.

2.19.13.6 In the event the Contractor fails to demonstrate through these tests that it can restore Systems functions, the Contractor 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.

2.19.14 Off Site Storage and Remote Back-up

2.19.14.1 The Contractor shall provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.

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

2.19.14.2.1 Descriptions of the controls for back-up processing, including how frequently back-ups occur;

2.19.14.2.2 Documented back-up procedures;

2.19.14.2.3 The location of data that has been backed up (off-site and on-site, as applicable);

2.19.14.2.4 Identification and description of what is being backed up as part of the back-up plan;

2.19.14.2.5 Any change in back-up procedures in relation to the Contractor's technology changes; and

2.19.14.2.6 A list of all back-up files to be stored at remote locations and the frequency with which these files are updated.

2.19.15 Records Retention

2.19.15.1 The Contractor shall have online retrieval and access to documents and files for audit and reporting purposes for ten (10) years in live systems and an additional four (4) years in archival systems. Historical encounter data submission shall be retained for a period not less than ten (10) years, following generally accepted retention

guidelines. Services which have a once in a lifetime indicator (i.e., appendix removal, hysterectomy) 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 recipient ID, provider ID, provider NPI, and/or ICN (internal control number) to include pertinent claims data and claims status.

2.19.15.2 Audit trails shall be maintained online for no less than six (6) years.

2.19.15.3 The Contractor shall provide access to information in machine-readable format within forty-eight (48) hours of requests for information less than six (6) years old and within seventy-two (72) hours of requests for information greater than six (6) years old.

2.19.15.4 If an audit or administrative, civil, or criminal investigation or prosecution is in progress or unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

2.19.15.5 Under no circumstances shall the Contractor destroy or dispose of any such records, even after the expiration of the retention periods provided above, without the express prior written permission of LDH.

2.19.16 Information Security and Access Management

The Contractor's system shall:

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

2.19.16.1.1 Establish unique access identification per MCO employee;

2.19.16.1.2 Restrict access to information on a "least privilege" basis, such as users permitted inquiry privileges only shall not be permitted to modify information;

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

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

2.19.16.2 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.

2.19.16.3 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 Contractor and LDH.

2.19.16.4 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:

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

2.19.16.4.2 Have the date and identification "stamp" displayed on any online inquiry;

2.19.16.4.3 Have the ability to trace data from the final place of recording back to its source data file and/or document;

2.19.16.4.4 Be supported by listings, transaction reports, update reports, transaction logs, or error logs; and

2.19.16.4.5 Facilitate auditing of individual records as well as batch audits.

2.19.16.5 Have inherent functionality that prevents the alteration of finalized records;

2.19.16.6 Provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The Contractor shall provide LDH with access to data facilities upon request. The physical security provisions shall be in effect for the life of the Contract;

2.19.16.7 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;

2.19.16.8 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;

2.19.16.9 Put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a Contractor'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;

2.19.16.10 Ensure that remote access users of its Systems can only access said Systems through two-factor user authentication and via methods such as Virtual Private Network (VPN), which must be prior approved by LDH as part of readiness reviews;

2.19.16.11 Comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. As a minimum, the

Contractor shall conduct a security risk assessment and communicate the results in an Information Security Plan provided no later than fifteen (15) calendar days after the Contract award. The risk assessment shall also be made available to appropriate federal agencies;

2.19.16.12 Ensure appropriate protections of shared Personally Identifiable Information ("PII"), in accordance with 45 C.F.R. §155.260; and

2.19.16.13 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.

2.19.16.13.1 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.

2.19.16.13.2 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.

2.20 Fraud, Waste, and Abuse Prevention

2.20.1 General Provisions

2.20.1.1 The Contractor and its subcontractors shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs including, but not limited to, 42 C.F.R. Part 438, Subparts A and H; La. R.S. 46:437.1 through 437.14; 42 C.F.R. Part 455, Subpart A; LAC 50:I, Subpart 5; and 42 U.S.C. §1320a-7, §1320c-5, and §1396a(a)(68).

2.20.1.2 The Contractor's Compliance Officer and CEO or COO shall meet in person, unless otherwise approved by LDH, with LDH and the Louisiana Office of Attorney General Medicaid Fraud Control Unit (MFCU) at LDH's request to discuss fraud, abuse, waste, neglect and overpayment issues. For purposes of this Section, the Contractor's Compliance Officer shall serve as the primary point of contact for the Contractor on issues related to Fraud, Abuse, and Waste Prevention.

2.20.1.3 The Contractor and its subcontractors shall cooperate and assist the State and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, 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 period and for a period of ten (10) years from the

expiration date of the Contract (including any extensions to the Contract) or from the date of completion of any audit, whichever is later, shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the Contract and any other applicable rules. MFCU shall be allowed access to the Contractor's 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 shall be allowed.

2.20.1.4 The Contractor and its providers and subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above upon request. HHS, OIG, LDH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with Contractor clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract.

2.20.1.5 The Contractor and its providers and subcontractors shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

2.20.1.6 The Contractor's employees, consultants, and its subcontractors and their employees shall cooperate fully and be available in person for interviews, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other investigative or judicial processes.

2.20.1.7 The Contractor shall certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The Contractor 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 applicable federal and state law, regulations, the Contract, and the **MCO Manual**.

2.20.1.8 The Contractor and its subcontractors shall have programs and procedures pursuant to 42 C.F.R. §438.608(a)(1) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The Contractor 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.

2.20.1.9 The Contractor, as well as its subcontractors and providers, shall comply with all federal requirements (42 C.F.R. §455.104, 42 C.F.R. §438.608(c), and 42 C.F.R. §438.610) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 C.F.R. Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial

contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request by LDH.

2.20.1.10 The Contractor, as well as its subcontractors and providers, shall comply with all federal requirements (42 C.F.R. Part 1002) 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 the State and/or the Contractor dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

2.20.1.11 The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud, waste, and abuse. At a minimum, the Contractor shall have one (1) full-time investigator physically located within Louisiana for every 50,000 enrollees or fraction thereof. This full-time position must be located in Louisiana. LDH may approve written requests with detailed justification to substitute another SIU position in place of an investigator position.

2.20.1.12 Reporting and Investigating Suspected Fraud and Abuse

2.20.1.12.1 The Contractor shall have methods for identification, investigation, and referral of suspected fraud cases (42 C.F.R. §455.13, §455.14, and §455.21) both internally and for its subcontractors.

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

2.20.1.12.2.1 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;

2.20.1.12.2.2 Triage and/or substantiate tips and provide updates to MFCU and LDH when the concerns and/or allegations of any tips are authenticated;

2.20.1.12.2.3 Suspected fraud and/or abuse in the administration of the program shall be reported in writing to LDH Program Integrity and MFCU within five (5) business days of the Contractor becoming aware of the issue;

2.20.1.12.2.4 All confirmed or suspected provider fraud and abuse shall immediately be reported in writing to LDH Program Integrity and MFCU; and

2.20.1.12.2.5 All confirmed or suspected enrollee fraud and abuse shall be reported immediately, in writing, to LDH Program Integrity and local law enforcement of the enrollee's parish of residence.

2.20.1.12.3 When making a referral of suspected fraud, the Contractor shall utilize the **LDH Provider Fraud Referral Form** available in the **MCO Manual**.

2.20.1.12.4 The Contractor 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 Contractor shall not take any of the following actions as they specifically relate to Medicaid claims:

2.20.1.12.4.1 Contact the subject of the investigation about any matters related to the investigation;

2.20.1.12.4.2 Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

2.20.1.12.4.3 Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

2.20.1.12.5 The Contractor 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.

2.20.1.12.6 The Contractor and its subcontractors shall seek to reduce prospective financial loss to health fraud, waste, and abuse when fraudulent and/or criminal activity is suspected through pre-payment or post-payment review, audit or investigation. The Contractor may mitigate loss of funds to fraud by employing procedures including, but not limited to, pre-payment edits, prior authorization, medical necessity review, verification of services being rendered as billed, payment withhold in full or in part, corrective action plans, termination of the provider agreement, or other remedies.

2.20.1.12.7 The Contractor and/or is subcontractors shall suspend 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 42 C.F.R. §455.23.

2.20.1.13 The Contractor and/or subcontractors shall include in all of its provider agreements a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider complies with this Section of the Contract.

2.20.2 Fraud, Waste, and Abuse Compliance Plan

2.20.2.1 In accordance with 42 C.F.R. §438.608(a), the Contractor 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.

2.20.2.2 In accordance with 42 C.F.R. §438.608(a), the arrangements and procedures of the compliance program shall include all of the following elements:

2.20.2.2.1 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.

2.20.2.2.2 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.

2.20.2.2.3 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.

2.20.2.2.4 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.

2.20.2.2.4.1 Fraud, Waste and Abuse Training shall include, but not be limited to:

- Annual training of all employees; and
- New hire training within thirty (30) calendar days of beginning date of employment.

2.20.2.2.4.2 The Contractor shall require new employees to complete and attest to training modules within thirty (30) calendar days of hire related to the following in accordance with federal and state laws:

- Contractor Code of Conduct Training;
- Privacy and Security – Health Insurance Portability and Accountability Act;
- Fraud, waste, and abuse identification and reporting procedures;
- The False Claims Act and employee whistleblower protections;
- Procedures for timely consistent exchange of information and collaboration with LDH;
- Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and
- Provisions that comply with 42 C.F.R. §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 LDH, HHS, CMS, and the U.S. 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.

2.20.2.2.5 Effective lines of communication between the compliance officer and the organization's employees.

2.20.2.2.6 Enforcement of standards through well-publicized disciplinary guidelines.

2.20.2.2.7 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.

2.20.2.2.8 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.

2.20.2.2.9 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.

2.20.2.2.10 Procedures for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract.

2.20.2.2.11 Protections to ensure that no individual who reports program integrity related violations or suspected fraud, waste, 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 confidential 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.

2.20.2.2.12 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.

2.20.2.2.13 Procedures for prompt reporting to the State of all overpayments identified and recovered, specifying the overpayments due to potential fraud.

2.20.2.3 In addition to the arrangements and procedures specified in 42 C.F.R. §438.608(a), the Contractor's compliance program shall incorporate the following requirements:

2.20.2.3.1 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.

2.20.2.3.2 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 Contractor and law enforcement.

2.20.2.3.3 Provisions for the confidential reporting of plan violations, such as a dedicated toll-free 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.

2.20.2.3.4 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.

2.20.2.4 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 this Contract. The Contractor shall implement procedures to review complaints filed in the fraud reporting email account at least weekly, and investigate and act on such complaints as warranted. The Contractor shall submit the Fraud, Waste, and Abuse Compliance Plan as part of readiness reviews, annually thereafter, and upon updates or modifications to LDH for approval at least thirty (30) calendar days in advance of making them effective. LDH, at its sole discretion, may require that the Contractor modify its compliance plan.

2.20.3 Prohibited Affiliations

2.20.3.1 In accordance with 42 C.F.R. §438.610, the Contractor and its subcontractors are prohibited from knowingly having a relationship with:

2.20.3.1.1 An individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

2.20.3.1.2 An individual or entity that is excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a.

2.20.3.2 The Contractor shall not have a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with:

2.20.3.2.1 An individual convicted of crimes described in 42 U.S.C. §1320a-7(b)(8)(B);

2.20.3.2.2 Any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

2.20.3.2.3 Any individual or entity that is excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a.

2.20.3.3 The Contractor is prohibited from employing or contracting, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with:

2.20.3.3.1 Any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;

2.20.3.3.2 Any individual or entity that is excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a;

2.20.3.3.3 Any individual or entity that would (or is affiliated with a person/entity that would) provide those services through an individual or entity debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

2.20.3.3.4 Any individual or entity that would provide those services through an individual or entity excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a.

2.20.3.4 The Contractor is prohibited from being controlled by a sanctioned individual under 42 U.S.C. §1320a-7(b)(8).

2.20.3.5 If LDH finds the Contractor is not in compliance with 42 C.F.R. §438.610(a) and (b), LDH:

2.20.3.5.1 Shall notify the Secretary of the U.S. Department of Health and Human Services (HHS) of the noncompliance;

2.20.3.5.2 May continue an existing agreement with the Contractor unless the Secretary of HHS directs otherwise;

2.20.3.5.3 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

2.20.3.5.4 Nothing in this section shall be construed to limit or otherwise affect any remedies available to the U.S. under 42 U.S.C. §1320a-7, §1320a-7a, and §1320a-7b.

2.20.3.6 The Contractor and its subcontractors shall comply with all applicable provisions of 42 C.F.R. §438.608 and §438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. The Contractor 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 Contractor shall conduct screenings to comply with the requirements set forth at 42 C.F.R. §455.436.

2.20.3.7 The Contractor 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 shall 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 42 U.S.C. §1320a-7a(a)(6) and 42 C.F.R. §1003.102(a)(2).]

2.20.3.8 An individual who is an affiliate of a prohibited person or entity described above can include:

- A director, officer, or partner of the Contractor;
- A subcontractor of the Contractor;
- A person with an employment, consulting or other arrangement with the Contractor for the provision of items and services which are significant and material to the Contractor's obligations under this Contract; or
- A network provider.

2.20.3.9 The Contractor shall notify LDH in writing within three (3) calendar days of the time it receives notice that action is being taken against the Contractor or any person defined above or under the provisions of 42 U.S.C. §1320a-7(a) or (b) or any contractor which could result in exclusion, debarment, or suspension of the Contractor 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.

2.20.3.10 The Contractor, through its Contract Compliance Officer, shall attest monthly to LDH that it has screened all employees and subcontractors as specified in the *Debarment/Suspension/Exclusion* section to capture all exclusions.

2.20.4 Payments to Excluded Providers

2.20.4.1 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 C.F.R. §1001.1901; and

2.20.4.2 The Contractor 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 Contractor to ensure compliance with requirements to prevent and return, as applicable, payments to excluded providers may also result in LDH assessing monetary penalties and/or other remedies according to Attachment E, *Table of Monetary Penalties*.

2.20.5 Reporting

2.20.5.1 The Contractor and its subcontractors shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the Louisiana Office of Attorney General MFCU and LDH as soon as practical after discovering suspected incidents, but no later than three (3) business days, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).

2.20.5.2 The Contractor shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the Contractor or Contractor's employee, network providers, subcontractor or subcontractor's employee under the provisions of 42 U.S.C. §1320(a) or (b), which could result in exclusion, debarment, or suspension of the Contractor, network provider, or a subcontractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

2.20.5.3 The Contractor shall report to LDH, within three (3) business days, when it has 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.

2.20.5.4 Reporting shall include, but is not limited to, as set forth at 42 C.F.R. §455.17:

2.20.5.4.1 Number of complaints of fraud, abuse, waste, neglect and overpayments made to the Contractor that warrant preliminary investigation (under 42 C.F.R. §455.14);

2.20.5.4.2 Number of complaints reported to the Contract Compliance Officer; and

2.20.5.4.3 For each complaint that warrants full investigation conducted in accordance with 42 C.F.R. §455.15 and §455.16, the Contractor shall provide LDH, at a minimum, the following:

- Provider Name and ID number;
- Source of complaint;
- Type of provider;
- Nature of complaint;
- Approximate amount of dollars involved if applicable; and
- Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.

2.20.5.5 The Contractor shall report to LDH Program Integrity monthly all audits performed and overpayments identified and recovered by the Contractor and all of its subcontractors. [See 42 C.F.R. §438.608(d)(3).]

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

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

2.20.6 Rights of Review and Recovery by Contractor and LDH

2.20.6.1 The Contractor and its subcontractors are responsible for investigating and reporting possible acts of provider fraud, abuse, and waste for all services under this contract.

2.20.6.2 The Contractor and its subcontractors shall have the right to audit, review and investigate providers and enrollees within the Contractor'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 Contractor's automated reviews are to remain with the Contractor. The Contractor shall not recover from providers via automated review for claims older than one (1) year unless authorized by LDH.

2.20.6.3 The Contractor and its subcontractors shall have the right to audit, review and investigate providers and members within the Contractor'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, were necessary to determine the existence of an improper payment. The collected funds from the Contractor's complex reviews are to remain with the Contractor.

2.20.6.4 All complex reviews shall be completed within eight (8) months (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.

2.20.6.5 The Contractor shall ensure compliance with all requirements of La. R.S. 46:460.72-460.73, 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.

2.20.6.6 The Contractor 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 within ten (10) business days, the Contractor may proceed with the review. The Contractor and its subcontractors shall not pursue recovery until approved by LDH.

2.20.6.7 LDH or its designee will notify the Contractor 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 (1) or more of the following criteria:

2.20.6.7.1 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, audit, and/or lawsuit including, but not limited to, False Claims Act cases; or

2.20.6.7.2 When the issues, services or claims that are the basis of the recoupment or withhold are the subject of pending state or federal investigation, audit, and/or lawsuit.

2.20.6.8 The 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 Contractor obtains funds in cases where recovery, recoupment or withhold is prohibited under this Section, LDH may recover the funds from the Contractor.

2.20.6.9 Contact with a provider shall be prohibited in instances resulting from suspected fraud, which the Contractor has identified and submitted a referral of fraud to LDH, MFCU, or other appropriate law enforcement agency, until approved by LDH.

2.20.6.10 If the Contractor fails to collect at least a portion of an identified recovery after three hundred sixty-five (365) calendar days from the date of notice to LDH, unless an extension or exception is authorized by LDH, and the Contractor has documented recovery efforts deemed sufficient by LDH upon review, LDH or its agent may recover the overpayment from the Contractor and said funds shall be retained by the State.

2.20.6.11 LDH or its agent shall have the right to audit, review and investigate providers and enrollees within the Contractor's network via "complex" or "automated" review. LDH may withhold from the Contractor any overpayments identified by LDH or its agent, and said recovered funds shall be retained by the State. The Contractor may pursue recovery from the provider as a result of the State-identified overpayment withhold. LDH shall not initiate its own review on the same claims for a network provider which has been identified by the Contractor as under a review approved by LDH. LDH shall track open LDH and Contractor reviews to ensure audit coordination. LDH shall not approve Contractor requests to initiate reviews when the audit lead and timeframe is already under investigation by LDH or its agents.

2.20.6.12 In the event LDH or its agent initiates a review on a network provider, a notification shall be sent to the Contractor 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 Contractor 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 Contractor within ten (10) business days, the State may proceed with its review.

2.20.6.13 In the event the State or its agent investigates, reviews, or audits a provider or enrollee within the Contractor's Network, the Contractor 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 Contractor and State.

2.20.6.14 LDH shall notify the Contractor and the network provider concurrently of overpayments identified by the State or its agents.

2.20.6.15 Upon the conclusion of provider rebuttals and appeals, if applicable, the State or its agent shall notify the Contractor of the overpayment. The Contractor shall correct or initiate its own review on the identified encounters within fourteen (14) calendar days of notification from LDH. The Contractor shall submit confirmation that the corrections have been completed.

2.20.6.16 The Contractor and its subcontractors shall enforce LDH directives regarding sanctions on MCO network providers and enrollees, including, but not limited to, termination or exclusion from the network.

2.20.6.17 There shall be no LDH provider improper payment recovery request of the Contractor applicable for the dates of service occurring before the start of the Medicaid Managed Care Contract period or for providers for which no MCO relationship existed.

2.20.6.18 The Contractor shall not remit payment to any provider for which the State-issued Medicaid Provider Identifier number has been revoked or terminated by LDH.

PART 3: STATE RESPONSIBILITIES

3.1 Contract Management

The Bureau of Health Services Financing (BHSF) is responsible for the primary oversight of the Contract, including Medicaid policy decision-making and Contract interpretation. As appropriate, BHSF shall provide clarification of Contract requirements and Medicaid policy, regulations and procedures and shall schedule meetings as necessary with the Contractor.

3.1.1 Contract Administration Personnel

3.1.1.1 The Contract Compliance Officer, described in the *Administration & Contract Management* section, shall facilitate the establishment and maintenance of direct relationships between the appropriate LDH business owners and MCO employees with corresponding responsibilities for the duration of the Contract.

3.1.1.2 The Contract Compliance Officer shall introduce MCO employees newly placed in a position to the relevant LDH business owners, based on roles and responsibilities, within five (5) business days of the placement.

3.1.2 Contract Monitor

Medicaid Director or his/her Designee
Louisiana Department of Health
Bureau of Health Services Financing
628 North 4th St., 7th floor
Baton Rouge, LA 70802

3.1.3 Notices

Any notice given to a party under the Contract is deemed effective, if addressed to the Contract Monitor as addressed above, upon: (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by facsimile or email if a copy of the notice is sent by another means specified in this Section; (iii) the third (3rd) business day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next business day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

Either party may change its address for notification purposes by providing written notice stating the change, effective date of the change and setting forth the new address at least ten (10) business 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 representatives shall be given in writing to the other party and attached to originals of the Contract.

Whenever LDH is required by the terms of this Contract to provide written notice to the Contractor, such notice shall be signed by the Medicaid Director or his/her designee.

3.1.4 Required Submissions

3.1.4.1 The Contractor shall submit documents and information in accordance with this Contract and the **MCO Manual**. LDH shall have the right to approve, disapprove, or require modification of these documents, information, and any procedures, policies and materials related to the Contractor's responsibilities under the terms of the Contract.

3.1.4.2 LDH shall review reports to determine that they are complete and without error according to the reporting requirements provided in the **MCO Manual**. Any reports found to be incomplete or submitted with errors shall be returned to the Contractor for correction and resubmission within specified timeframes.

3.1.5 Readiness Review Prior to Operational Start Date

3.1.5.1 LDH will assess the performance of the selected MCOs prior to and after the begin date for operations in accordance with 42 C.F.R. §438.66(d). LDH shall start the readiness review at least three (3) months prior to the operational start date and complete the reviews of MCOs prior to implementation. Each readiness review for entities that did not contract with LDH as an MCO immediately prior to the Contract effective date shall be performed on-site at the Contractor's Louisiana administrative offices and shall include an assessment of the Contractor's ability and capability to perform satisfactorily in the areas noted below as set forth in 42 C.F.R. §438.66(d)(4). LDH retains the discretion to conduct a more limited readiness review for existing MCO contractors. LDH may conduct additional readiness reviews of the Contractor prior to enrolling additional populations in managed care or prior to adding or deleting covered services from Attachment A, *MCO Covered Services*.

3.1.5.2 The scope of the Contractor's readiness review may include, but is not limited to, a review of the following elements against the requirements provided in this Contract and the **MCO Manual**:

3.1.5.2.1 Administrative staffing and resources, including key personnel;

3.1.5.2.2 Delegation and oversight of Contractor responsibilities, including capabilities of material subcontractors;

3.1.5.2.3 Enrollee and provider communications, including enrollee services capability;

3.1.5.2.4 Grievance and appeals;

3.1.5.2.5 Enrollee services and outreach, including marketing materials;

3.1.5.2.6 Provider network management plans and model provider agreements, including any provider performance incentives;

3.1.5.2.7 Program integrity and compliance, including fraud, waste, and abuse;

3.1.5.2.8 Service delivery, including care management capabilities, quality management and quality improvement, and utilization review;

3.1.5.2.9 Financial management, including financial reporting and monitoring and financial solvency; and

3.1.5.2.10 Systems management, including claims management, encounter data and enrollee information management, and, at the request of LDH, a walk-through of any information systems, interfacing and reporting capabilities, and validity testing of encounter data, including IT testing and security assurances.

3.1.5.3 LDH shall not enroll potential enrollees into the MCO until LDH determines that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the readiness review, except as provided below.

3.1.5.4 LDH shall identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and may, in its discretion:

3.1.5.4.1 Allow the Contractor to propose a plan to remedy all deficiencies prior to the Contract operational start date;

3.1.5.4.2 Postpone the Contract operational start date for any MCO that fails to satisfy all readiness review requirements; or

3.1.5.4.3 Enroll enrollees into the MCO as of the Contract operational start date provided the Contractor and LDH agree on a corrective action plan to remedy any deficiencies.

3.1.5.5 If, for any reason, the Contractor does not fully satisfy LDH that it is ready and able to perform its obligations under the Contract prior to the Contract operational start date, and LDH does not agree to postpone the Contract operational start date, or extend the date for full compliance with the applicable Contract requirement, then LDH may terminate the Contract and shall be entitled to recover damages from the Contractor.

3.1.5.6 LDH shall submit the results of the readiness review to CMS in order for CMS to make a determination that the Contract or associated Contract amendment is approved under 42 C.F.R. §438.3(a).

3.1.6 Ongoing Contract Monitoring

LDH shall monitor the Contractor's performance to ensure the Contractor is in compliance with Contract provisions. The Contractor remains responsible for continuously monitoring the performance of its material subcontractors and providers and their compliance with Contract provisions. LDH may develop, based on its ongoing monitoring, a public performance dashboard displaying the Contractor's performance.

3.1.6.1 LDH or its designee shall coordinate with the Contractor to establish the scope of the monitoring review, the review site, if on-site, relevant timeframes for obtaining information, and the criteria for review.

3.1.6.2 LDH or its designee shall monitor the operation of the MCO for compliance with the provisions of this Contract, and all applicable federal and state laws and regulations. Inspection may include the Contractor's facilities, as well as auditing and/or review of all records developed

under this Contract including, but not limited to, periodic medical audits, grievances, enrollments, disenrollments, utilization and financial records, review of the management systems and procedures developed under this Contract and any other areas or materials relevant or pertaining to this Contract.

3.1.6.3 The Contractor shall provide access to documentation, medical records, premises, and staff as deemed necessary by LDH.

3.1.6.4 LDH shall provide the Contractor with the right to review and comment on any of the findings and recommendations resulting from Contract monitoring and audits, except in the cases of fraud investigations or criminal action. Once LDH finalizes the results of monitoring and/or the audit report, the Contractor shall comply with all recommendations resulting from the review. Failure to comply with recommendations for improvement may result in monetary penalties, sanctions and/or enrollment restrictions.

3.1.7 MCO On-Site Reviews

LDH shall conduct on-site readiness reviews for the Contractor. Readiness reviews shall be completed prior to any enrollment under this Contract. Site reviews may also occur at any time during the course of the Contract to monitor Contractor performance.

LDH's on-site review of the Contractor shall include a desk audit and on-site focus component. The site review will focus on specific areas of Contractor performance. These focus areas may include, but are not limited to the following:

3.1.7.1 Administrative capabilities;

3.1.7.2 Governing body;

3.1.7.3 Material subcontracts;

3.1.7.4 Provider network capacity and services;

3.1.7.5 Provider complaints;

3.1.7.6 Enrollee services;

3.1.7.7 PCP assignments and changes;

3.1.7.8 Value-based payment;

3.1.7.9 Enrollee grievances and appeals;

3.1.7.10 Health education and promotion;

3.1.7.11 Quality improvement;

3.1.7.12 Utilization review;

3.1.7.13 Data reporting;

3.1.7.14 Population health;

3.1.7.15 Care management;

3.1.7.16 Coordination of care;

3.1.7.17 Claims processing;

3.1.7.18 Encounter data;

3.1.7.19 Fraud, waste, and abuse; and

3.1.7.20 Reporting requirements.

3.1.8 Regular Contract Monitoring Meetings

LDH shall assess and communicate feedback on overall plan performance to the Contractor through routine meetings with Contractor leadership, including but not limited to:

3.1.8.1 Monthly in-person or telephonic meetings between the Medicaid Director, Medicaid Deputy Director responsible for Medicaid managed care, and the Contractor's CEO.

3.1.8.2 Quarterly performance reviews wherein MCO leadership present to LDH leadership on overall MCO performance relative to LDH goals and the requirements of the Contract. The reviews shall take place in-person at LDH headquarters on a schedule determined by LDH. LDH shall notify the Contractor of the schedule and any format or content requirements thirty (30) calendar days prior to the review date. Unless otherwise specified by LDH, in-person attendance of the following Contractor staff is mandatory:

3.1.8.2.1 Chief Executive Officer (CEO);

3.1.8.2.2 Medical Director;

3.1.8.2.3 Behavioral Health Medical Director;

3.1.8.2.4 Chief Operating Officer (COO);

3.1.8.2.5 Chief Financial Officer (CFO);

3.1.8.2.6 Quality Management Coordinator;

3.1.8.2.7 Provider Services Manager;

3.1.8.2.8 Case Management Administrator/Manager; and

3.1.8.2.9 Other staff as designated by LDH based on content.

3.1.9 Contractor Monitoring

3.1.9.1 LDH shall:

3.1.9.1.1 Monitor compliance with the terms of the Contract;

3.1.9.1.2 Receive and respond to all inquiries and requests made by the Contractor under this Contract, in the time frames specified by the Contract;

3.1.9.1.3 Meet with the Contractor's representative on a periodic or as needed basis and resolve issues that arise;

3.1.9.1.4 Ensure that LDH staff with appropriate expertise in clinical, financial, data, systems, marketing, enrollment, and quality management matters, are involved in the Contractor's QAPI program;

3.1.9.1.5 Ensure that appropriate staff from LDH agencies are available to assist the Contractor with care and service coordination activities;

3.1.9.1.6 Make best efforts to resolve any issues identified either by the Contractor or LDH that may arise that are applicable to the Contract;

3.1.9.1.7 Inform the Contractor of any discretionary action by LDH under the provisions of the Contract; and

3.1.9.1.8 Review and approve:

3.1.9.1.8.1 Transition Work Plan;

3.1.9.1.8.2 Remedy plan;

3.1.9.1.8.3 Predictive modeling methodology;

3.1.9.1.8.4 Key personnel and staffing plan;

3.1.9.1.8.5 Material subcontractors;

3.1.9.1.8.6 Performance review policies, procedures and work plan;

3.1.9.1.8.7 PCP automatic assignment methodology;

3.1.9.1.8.8 Material change in provider network;

3.1.9.1.8.9 Provider handbook;

3.1.9.1.8.10 Provider training manual and schedule;

3.1.9.1.8.11 Tentative prescriber training and education schedule or plan;

3.1.9.1.8.12 Utilization management reports;

3.1.9.1.8.13 Plan for long-term stays in emergency departments;

3.1.9.1.8.14 Press or media events/activities or activities that include sponsorship;

3.1.9.1.8.15 Telephone help line policies and procedures;

3.1.9.1.8.16 Call center quality criteria and protocols;

3.1.9.1.8.17 Quality deficiencies which result in suspension or termination of a network provider/subcontractor(s);

3.1.9.1.8.18 QAPI program description;

3.1.9.1.8.19 Internal claims dispute process;

3.1.9.1.8.20 Claims Payment Accuracy Percentage Report;

3.1.9.1.8.21 Pharmacy Benefits Manager (PBM);

3.1.9.1.8.22 Corrective action plans;

3.1.9.1.8.23 System update and/or change revisions;

3.1.9.1.8.24 Systems Refresh Plan;

3.1.9.1.8.25 Contingency Plan;

3.1.9.1.8.26 Information Security Plan;

3.1.9.1.8.27 Fraud, Waste, and Abuse Compliance Plan;

3.1.9.1.8.28 VBP Strategic Plan;

3.1.9.1.8.29 Turnover Plan;

3.1.9.1.8.30 Turnover Results report;

3.1.9.1.8.31 Insurance policies;

3.1.9.1.8.32 Reinsurance agreements;

3.1.9.1.8.33 Emergency Management Plan;

3.1.9.1.8.34 Requests for exemptions to requirements as allowed by this Contract; and

3.1.9.1.8.35 Other deliverables and information as required in the Contract and **MCO Manual**.

3.1.9.2 If LDH determines that the Contractor is in violation of any of the terms of the Contract stated herein, at its sole discretion, it may apply one (1) or more of the actions provided in the *Contract Non-Compliance* section, including termination of the Contract; provided, however, that LDH shall only impose those actions that it determines to be reasonable and appropriate

for the specific violation(s) identified. LDH shall notify the appropriate entities, including, but not limited to, the Secretary of the U.S. Department of Health and Human Services (HHS), of such non-compliance.

3.1.9.3 LDH shall notify the Contractor, as promptly as is practicable, of any providers suspended or terminated from participation in Louisiana Medicaid so that the Contractor may take action to remove such provider from their provider network.

3.1.10 Data Sharing

LDH shall share available public health data on enrollees with the Contractor including, but not limited to, the following:

3.1.10.1 Immunization data for enrollees through the month of their twenty-first (21st) birthday; and

3.1.10.2 Vital records data.

3.1.11 Coordination of Benefits

3.1.11.1 LDH or its contractor shall provide the Contractor with all third-party health insurance information on enrollees when it has verified that third party health insurance exists.

3.1.11.2 When LDH has knowledge that an enrollee has been involved in an accident or has had a traumatic event and a liable third party might exist, LDH shall notify the Contractor and provide the enrollee's name and pertinent information.

3.1.11.3 LDH shall develop base capitation rates that are net of expected TPL recoveries, consistent with the Contractor's obligation under this Contract, to recover claims paid to providers when a third-party was the primary insurer.

3.1.12 Enrollment, Assignment, and Disenrollment Process

3.1.12.1 Enrollment Verification

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

3.1.12.2 Enrollment

LDH shall:

3.1.12.2.1 Maintain sole responsibility for the enrollment of LDH Medicaid beneficiaries into the MCO, as described in the *Eligibility and Enrollment* 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;

3.1.12.2.2 Make available to the Contractor each business day, via the 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;

3.1.12.2.3 At its discretion, automatically re-enroll on a prospective basis in the MCO, enrollees who were disenrolled from the MCO due to loss of eligibility and whose eligibility was reestablished by LDH;

3.1.12.2.4 At its discretion, auto-assign potential enrollees to the MCO based on a methodology defined by LDH; no auto-assignments shall occur once the Contractor's enrollment capacity reaches ninety-five (95%) or if thirty-five (35%) or more of the total Medicaid managed care eligible population is enrolled in the MCO;

3.1.12.2.5 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

3.1.12.2.6 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.

3.1.12.3 Automatic Assignment

3.1.12.3.1 LDH shall auto-assign potential enrollees who do not request enrollment in a specified MCO at the time of financial application for Medicaid or through the help of the enrollment broker, or who cannot be enrolled into the requested MCO for reasons including, but not limited to, the MCO having reached its enrollment capacity limit or as a result of LDH-initiated sanctions. As specified in the *Eligibility and Enrollment* section, enrollees who fail to select a new MCO during their annual open enrollment period shall remain enrolled with their existing MCO. These enrollees shall not be subject to the automatic assignment process.

3.1.12.3.2 In accordance with 42 C.F.R. §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 MCOs, excluding those subject to the intermediate sanction described in 42 C.F.R. §438.702(a)(4).

3.1.12.3.3 If the Contractor is noncompliant with the terms of this 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 an MCO from automatic assignment or to take any other punitive action shall not constitute ratification or approval of such noncompliance.

3.1.12.3.4 The automatic assignment methodology for all populations shall be based on the following hierarchy:

3.1.12.3.4.1 If the enrollee has made a prior MCO selection at the time of Medicaid application, the enrollee shall be enrolled in that MCO.

3.1.12.3.4.2 If the enrollee has a current DCFS segment, the enrollee shall follow the DCFS automatic assignment process.

3.1.12.3.4.3 If the enrollee has household enrollees enrolled in an MCO, the enrollee shall be enrolled in that MCO. If multiple MCO linkages exist within the household, the enrollee shall be enrolled to the MCO of the youngest household enrollee.

3.1.12.3.4.4 If MCO assignment cannot be made based on the beneficiary's household enrollment, the enrollment broker shall seek to preserve existing provider-beneficiary relationships. If a provider relationship is identified, the beneficiary shall be assigned to the MCO in which the provider participates with the lowest automatic assignment enrollments.

3.1.12.3.4.5 If there is no previous provider relationship, the enrollment broker shall seek to preserve prior MCO relationships within the past six (6) months. If a MCO relationship is identified, the beneficiary shall be assigned to the most recent MCO.

3.1.12.3.4.6 If there is no previous MCO relationship, the enrollment broker shall use a round robin method to determine the MCO assignment.

3.1.12.3.4.7 If an MCO's membership is comprised of thirty-five percent (35%) or more of total statewide membership at the end of any quarter, the MCO will be removed from the auto assignment round robin process for the following quarter, but enrollees can continue to pro-actively select that MCO.

3.1.12.3.4.8 In addition, the MCO's quality measures may be factored into the algorithm for automatic assignment, at the discretion of LDH.

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

3.1.12.4 Disenrollment

3.1.12.4.1 Disenrollment Conditions

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

3.1.12.4.1.1 Loss of Louisiana Medicaid eligibility;

3.1.12.4.1.2 Completion of the enrollee's voluntary disenrollment request;

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

3.1.12.4.1.4 Loss of eligibility for Louisiana Medicaid Managed Care.

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

3.1.12.4.2.1 For cause, at any time, in accordance with 42 C.F.R. §438.56(d);

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

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

3.1.12.4.3 Disenrollment Information

LDH shall:

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

3.1.12.4.3.2 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.

3.1.12.5 Enrollment Broker

LDH or its designee shall:

3.1.12.5.1 Develop generic materials to assist enrollees in choosing whether to enroll in the MCO. Said materials shall present the MCO in an unbiased manner to potential enrollees. LDH may collaborate with the Contractor in developing MCO-specific materials;

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

3.1.12.5.2.1 The nature of the requirements of participation in an MCO, including but not limited to:

- Use of Network Providers;
- Maintenance of existing relationships with Network Providers; and
- The importance of Primary Care;

3.1.12.5.2.2 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 MCO; and

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

3.1.12.5.3 Enroll, disenroll and process transfer requests of enrollees in the MCO, including completion of LDH's enrollment and disenrollment forms, except enrollment forms for newborn enrollees;

3.1.12.5.4 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;

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

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

3.1.12.5.7 Include all contracted MCOs in all LDH-sponsored open enrollment activities.

3.1.13 Marketing

3.1.13.1 LDH shall monitor the Contractor's marketing activities and distribution of related materials.

3.1.13.2 Within thirty (30) calendar days of receipt of marketing material submitted by the Contractor in compliance with the *Enrollee Services* and *Marketing and Education* section, LDH shall take one of the following actions:

3.1.13.2.1 Approve or disapprove the marketing material;

3.1.13.2.2 Require modification to the marketing material; or

3.1.13.2.3 Notify the Contractor that LDH requires an additional ten (10) business days from the date of such notification to take the actions described above.

3.1.13.3 The Contractor shall comply with any such LDH action. LDH's failure to take any of the actions described above within thirty (30) business days after receipt of the Contractor's marketing material, shall be deemed to constitute approval of said marketing material. Further, LDH's failure to take any of the actions described above within ten (10) business days after notification to the Contractor, shall be deemed to constitute approval of the marketing material, as shall LDH's failure to respond within ten (10) business days of receipt of modifications to marketing materials submitted to LDH pursuant to the above.

3.1.14 Additional Enrollee Groups and Covered Services

LDH may:

3.1.14.1 Add, delete or otherwise change mandatory, voluntary opt-out, voluntary opt-in and excluded population groups to the Contract, with sixty (60) calendar days advance notice to the Contractor, when possible;

3.1.14.2 Develop and implement the necessary processes and procedures required to implement enrollment of additional enrollee groups, as further specified by LDH;

3.1.14.3 Amend Medicaid covered services and modify the Contractor's covered services required, including adding covered services consistent with State Plan Amendment, federal waiver or other required state authorities;

3.1.14.4 Develop reimbursement rate(s) that account for the above changes to enrollee groups or covered services consistent with state and federal authorities as applicable; and

3.1.14.5 Develop, in cooperation with the Contractor, an implementation strategy for providing services to enrollees.

3.1.15 Health Needs Assessment Instrument (HNA)

3.1.15.1 LDH shall provide the Contractor with the HNA instrument, which shall include the minimum necessary set of questions to identify an enrollee as potentially requiring case management support. The HNA will aim to identify physical, behavioral and SDOH risk factors.

3.1.15.2 HNA questions shall include:

3.1.15.2.1 Enrollee demographics, personal health history, including chronic conditions and previous and current treatment for physical and behavioral health care needs, and self-perceived health status;

3.1.15.2.2 Questions to identify enrollees' needs for culturally and linguistically appropriate services including, but not limited to, hearing and vision impairment and language preference;

3.1.15.2.3 Questions to identify the enrollee's health concerns and goals;

3.1.15.2.4 Questions to identify potential gaps in care; and

3.1.15.2.5 Questions to identify enrollees' health-related social needs, including housing, food insecurity, physical safety, and transportation.

3.2 Contract Non-Compliance

When LDH identifies that the Contractor is not compliant with the terms of the contract, LDH may pursue administrative actions, corrective action plans, and/or monetary penalties.

3.2.1 Administrative Actions

3.2.1.1 Administrative actions exclude monetary penalties, corrective action plans, intermediate sanctions and Contract termination and include, but are not limited to:

3.2.1.1.1 A warning through written notice or consultation;

3.2.1.1.2 Education requirement regarding program policies and procedures;

3.2.1.1.3 Review of the Contractor's business processes;

3.2.1.1.4 Referral to the Louisiana Department of Insurance for investigation;

3.2.1.1.5 Referral for review by appropriate professional organizations;

3.2.1.1.6 Referral to the Office of the Attorney General for fraud investigation; and/or

3.2.1.1.7 Exclusion from Automatic Assignment – LDH may exclude the Contractor from any or all components of the automatic assignment process described in the *State Responsibilities, Contract Management* section for the duration of the noncompliance. During this period of exclusion, enrollees shall be automatically assigned under the terms of the *State Responsibilities, Contract Management* section as if the excluded MCO were not a participant in the assignment process. Upon determining that the noncompliance has been satisfactorily cured and the thirty (30) calendar day minimum exclusion period has lapsed, LDH shall return the Contractor to the automatic assignment process but shall not take any action to return the Contractor to the position it would have been in had it not been excluded.

3.2.2 Corrective Action Plans

3.2.2.1 LDH may require the Contractor to develop a Corrective Action Plan (CAP) that includes the steps to be taken by the Contractor to obtain compliance with the terms of the Contract. A CAP is not required before LDH may pursue the application of any other non-compliance action authorized in the Contract.

3.2.2.2 LDH shall approve and monitor implementation of the CAP through available reporting resources, on-site evaluations, or requested status reports.

3.2.2.3 The CAP shall include a timeframe for anticipated compliance and a date certain for the correction of the non-compliance.

3.2.2.4 LDH may impose monetary penalties if the terms of the CAP are not met. Monetary penalties shall continue until satisfactory correction of the non-compliance has been made as determined by LDH.

3.2.3 Monetary Penalties

3.2.3.1 General Information

3.2.3.1.1 Failure to comply with the requirements and performance standards set forth in this Contract may result in the assessment of a monetary penalty per incident of non-compliance. Determinations of non-compliance may be based on findings from a review of deliverables, enrollee or provider complaints, or any other reliable source.

3.2.3.1.2 The purpose of establishing and imposing monetary penalties is to provide a means for LDH to obtain the services and level of performance required for successful operation of the Contract. LDH's failure to assess monetary penalties in one or more of the particular instances described herein shall not waive the right of LDH to assess monetary penalties or actual damages in the future.

3.2.3.1.3 For purposes of this section, violations involving individual, unrelated acts shall not be considered as arising out of the same action.

3.2.3.1.4 Attachment E, *Table of Monetary Penalties* specifies permissible monetary penalties for certain violations of the Contract. For any violation not explicitly described in the table, LDH may impose a monetary penalty of up to five thousand dollars ($5,000) per occurrence per calendar day.

3.2.3.2 Notices of Action

3.2.3.2.1 LDH may first notify the Contractor of incidents of non-compliance and of LDH's authority to impose a monetary penalty via a Notice of Action (NOA). The NOA will include the basis and nature of the violation, the relevant contract sections and/or provisions of law, the deadline to cure the violation, and the methodology for calculation of any monetary penalty if the violation is not cured by the established deadline.

3.2.3.2.2 LDH may require the Contractor to provide a written response with a detailed explanation of the reasons for the violation, the Contractor's assessment or diagnosis of the cause, and Contractor's plan to address or cure the deficiency within the timeframe set forth in the NOA.

3.2.3.2.3 The Contractor's repeated commission of deficiencies or repeated failure to resolve any such deficiencies may entitle LDH to pursue any other remedy provided in the Contract or any other appropriate remedy LDH may have at law.

3.2.3.2.4 At any time and at its discretion, LDH may impose or pursue one or more remedies for each item of noncompliance and will determine remedies on a case-by-case basis.

3.2.3.3 Notices of Monetary Penalty

Monetary penalties may be assessed against the Contractor at the sole discretion of LDH. LDH will notify the Contractor of the assessment of monetary penalties via a Notice of Monetary Penalty (NMP).

3.2.3.4 Disputes and Appeals

3.2.3.4.1 If LDH chooses to notify the Contractor of incidents of non-compliance and of LDH's authority to impose a penalty via a NOA prior to assessing the penalty, the Contractor may dispute infractions contained within the NOA through the following process:

3.2.3.4.1.1 Within seven (7) calendar days after receipt of the NOA, the Contractor shall submit its dispute of the NOA directly to the Medicaid Deputy Director or

his/her designee in writing via e-mail; this submission shall include all arguments, materials, data, and information necessary to resolve the dispute.

3.2.3.4.1.2 The Contractor shall waive any dispute or argument not raised within seven (7) calendar days of receiving the NOA. The Contractor shall also waive the right to use any materials, data, and/or information not contained in or accompanying the Contractor's submission submitted within the seven (7) calendar days following its receipt of the notice in any subsequent NMP issued should the Contractor fail to demonstrate compliance as stated in the NOA.

3.2.3.4.1.3 The Medicaid Deputy Director or his/her designee will decide the dispute, reduce the decision to writing, and provide a copy to the Contractor. This written decision will be final.

3.2.3.4.2 To appeal the assessment of a monetary penalty:

3.2.3.4.2.1 Within seven (7) business days of receipt of the NMP, the Contractor shall submit its appeal in writing to the Medicaid Deputy Director or his/her designee. LDH will issue a written decision within fifteen (15) business days of the appeal.

3.2.3.4.2.2 Within five (5) business days of receipt of LDH's written decision, the Contractor may request reconsideration of the decision in writing to the LDH Medicaid Director. The LDH Medicaid Director shall issue a written opinion within thirty (30) calendar days. No further appeals to LDH shall be allowed.

3.2.4 Intermediate Sanctions

3.2.4.1 Acts or Failures to Act Subject to Intermediate Sanctions

Pursuant to 42 C.F.R. Part 438, Subpart I, LDH may impose on the Contractor intermediate sanctions if it determines that the Contractor:

3.2.4.1.1 Fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under the Contract, to an enrollee covered under the Contract;

3.2.4.1.2 Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Louisiana Medicaid managed care program;

3.2.4.1.3 Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment, refusal to reenroll an enrollee, except as permitted in the *Eligibility and Enrollment* section, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services;

3.2.4.1.4 Misrepresents or falsifies information that it furnishes to CMS or to LDH;

3.2.4.1.5 Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or a health care provider;

3.2.4.1.6 Fails to comply with the requirements for physician incentive plans, as set forth in 42 C.F.R. §438.3(i), §422.208, and §422.210;

3.2.4.1.7 Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by LDH or that contain false or materially misleading information; or

3.2.4.1.8 Violates any of the other applicable requirements of 42 U.S.C. §1396b(m), §1396d(t)(3), or §1396u-2 and any implementing regulations.

3.2.4.2 Other Misconduct Subject to Intermediate Sanctions

LDH also may impose sanctions against the Contractor if it finds any of the following non-exclusive actions/occurrences:

3.2.4.2.1 The Contractor has failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from LDH;

3.2.4.2.2 The Contractor has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to the Medicare-Medicaid Anti-Fraud and Abuse Amendments, Public Law 95-142;

3.2.4.2.3 The Contractor or any of its owners, officers or directors has been convicted of a criminal offense relating to performance of the Contract with LDH or of fraudulent billing practices or of negligent practice resulting in death or injury to the Contractor's enrollee;

3.2.4.2.4 The Contractor has presented, or has caused to be presented, any false or fraudulent claim for services or has submitted, or has caused to be submitted, false information to be furnished to the State or the Secretary of the federal Department of Health and Human Services;

3.2.4.2.5 The Contractor has engaged in a practice of charging and accepting payment (in whole or part) from enrollees for services for which a PMPM payment was made by LDH;

3.2.4.2.6 The Contractor has rebated or accepted a fee or portion of fee or charge for a patient referral;

3.2.4.2.7 The Contractor has failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments;

3.2.4.2.8 The Contractor has failed to keep or make available for inspection, audit or copying, such records regarding payments claimed for providing services;

3.2.4.2.9 The Contractor has failed to furnish any information requested by LDH regarding payments for providing goods or services;

3.2.4.2.10 The Contractor has made, or caused to be made, any false statement or representation of a material fact to LDH or CMS in connection with the administration of the Contract; or

3.2.4.2.11 The Contractor has furnished goods or services to an enrollee which at the sole discretion of LDH, and based on competent medical judgment and evaluation are determined to be 1) insufficient for his or her needs, 2) harmful to the enrollee, or 3) of grossly inferior quality.

3.2.4.3 Sanction Types

The types of intermediate sanctions that LDH may impose on the Contractor shall be in accordance with Act (42 U.S.C. §1396u-2) and 42 C.F.R. §438.702 through §438.708 and may include any of the following:

3.2.4.3.1 Civil monetary penalties in the amounts specified in 42 C.F.R. §438.704;

3.2.4.3.2 Appointment of temporary management for an MCO as provided in 42 C.F.R. §438.706;

3.2.4.3.3 Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;

3.2.4.3.4 Suspension of all new enrollments, including automatic assignment, after the effective date of the sanction and for a time period determined by LDH;

3.2.4.3.5 Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or LDH is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur in accordance with 42 C.F.R. §438.730; and

3.2.4.3.6 Additional sanctions allowed under State statutes or regulations that address areas of noncompliance described above.

3.2.4.3.7 LDH may require the Contractor to develop a Corrective Action Plan, as described in this section, to address areas of non-compliance subject to intermediate sanctions.

3.2.4.3.8 Except as provided in this section, before imposing any intermediate sanctions, LDH shall give the Contractor timely written notice that explains the basis and nature of the sanction and any other due process protections.

3.2.4.4 Notice to CMS

LDH shall give the CMS Regional Office written notice whenever it imposes or lifts an intermediate sanction for one of the violations listed in 42 C.F.R. §438.700, specifying the affected MCO, the kind of sanction, and the reason for LDH's decision to impose or lift a sanction. Notice will be given no later than thirty (30) calendar days after LDH imposes or lifts the sanction.

3.2.5 Payment of Monetary Penalties and Intermediate Sanctions

3.2.5.1 Monetary penalties or intermediate sanctions assessed by LDH that cannot be collected through the capitated payment deduction specified in the *Payment and Financial Provisions, Return of Funds* section shall be due and payable to LDH within thirty (30) calendar days after the Contractor's receipt of the notice of monetary penalties or sanctions.

3.2.5.2 In the event an appeal by the Contractor results in a decision in favor of the Contractor, the penalty/sanction amount specified in the decision shall be returned to the Contractor.

3.2.5.3 LDH has the right to recovery of any amounts overpaid as the result of deceptive practices by the Contractor and/or its subcontractors, and may consider trebled damages, civil penalties, and/or other remedial measures.

3.2.5.4 A monetary penalty or sanction may be applied to all known affiliates, subsidiaries and parents of a Contractor, 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 Contractor is affiliated when such conduct was accomplished within the course of his official duty or was effectuated by him with the knowledge or approval of such person.

3.2.6 Termination of MCO Contract

3.2.6.1 Nothing in this Section shall limit LDH's right to terminate the Contract or to pursue any other legal or equitable remedies.

3.2.6.2 Pursuant to 42 C.F.R. §438.708, LDH may terminate the Contract and enroll that Contractor's enrollees in other MCOs or provide their benefits through other options included in the State Plan if LDH, at its sole discretion, determines that the Contractor has failed to: (1) carry out the substantive terms of the Contract, or (2) meet applicable requirements in 42 U.S.C. §1396b(m), §1396d(t), or §1396u-2.

3.2.6.3 LDH shall provide the Contractor with a timely written Notice of Intent to Terminate (Notice) that states the nature and basis of the termination and pre-termination hearing rights.

3.2.6.4 The termination shall be effective no less than thirty (30) calendar days from the date of the Notice of Intent to Terminate. The Contractor may, at the discretion of LDH, be allowed to correct the deficiencies within the thirty (30) calendar day notice period, unless other provisions in this Section demand otherwise, prior to the issuance of a Notice of Termination.

3.2.6.5 In accordance with 42 C.F.R. §438.710, LDH shall conduct a pre-termination hearing upon the request of the Contractor as outlined in the Notice of Intent to Terminate to provide the Contractor the opportunity to contest the nature and basis of the sanction.

3.2.6.6 The request shall be submitted in writing to the LDH Undersecretary prior to the determined date of termination stated in the Notice.

3.2.6.7 The Contractor shall receive a written notice of the outcome of the pre-termination hearing, if applicable, indicating decision reversal or affirmation.

3.2.6.8 The decision by the LDH Undersecretary shall be final and the Administrative Procedure Act, La. R.S. 49:950, et seq., does not apply. The Notice of Termination will state the effective date of termination.

3.2.6.9 LDH shall notify the Medicaid enrollees enrolled in the MCO in writing, consistent with 42 C.F.R. §438.710 and §438.722, of the affirming termination decision and of their options for receiving Medicaid services and their right to disenroll immediately without cause.

3.2.7 Payment of Outstanding Monies or Collections from MCO

The Contractor shall be paid for any outstanding monies due less any assessed monetary penalties or sanctions. If monetary penalties exceed monies due, collection may be made from the MCO Fidelity Bond, Performance Bond, Retainage, Errors and Omissions Insurance, or any insurance policy or policies required under this Contract. The rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

3.2.8 Provider Sanctions

Nothing contained herein shall prohibit LDH from imposing sanctions, including, but not limited to, civil monetary penalties, license revocation and Medicaid termination, upon a health care provider for its violations of federal or state law, rule, or regulations.

3.2.9 Independent Assurances

3.2.9.1 When required by LDH, the Contractor shall provide a quality control plan, such as third party Quality Assurance (QA), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits.

3.2.9.2 These audits shall require the Contractor to provide any assistance, records access, information system access, staff access, and space access to the party selected to perform the independent audit. The audit firm will submit to the State Agency and/or Contractor a final report on controls placed in operations for the project and includes a detailed description of the audit firm's tests of the operating effectiveness of controls.

3.2.9.3 The Contractor shall supply the LDH with an exact copy of the report within thirty (30) calendar days of completion. When required by LDH, such audits may be performed annually during the term of the Contract. The Contractor shall agree to implement recommendations as suggested by the audits within three (3) months of report issuance at no cost to the State. The cost of the audit is to be borne by the Contractor.

PART 4: PAYMENT AND FINANCIAL PROVISIONS

4.1 Capitated Payments

4.1.1 LDH shall make monthly capitated payments to each MCO based on its enrollment for the month.

4.1.2 Enrollment for the month is determined by the total number of enrollees linked to the MCO as of the first calendar day of the month, with capitation payments due in the following month. For age group assignment purposes, age shall be defined as of the beginning of the month for which the payment is intended.

4.1.3 LDH may make capitation payments on a lump sum basis when administratively necessary.

4.2 Maternity Kick Payments

4.2.1 LDH shall provide the Contractor with a one-time supplemental lump sum payment for each obstetrical delivery. This kick payment is intended to cover the cost of prenatal care, the delivery event, and post-partum care and uncomplicated newborn hospital costs. Kick payments may be differentiated between early elective delivery events and all other delivery events.

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

4.2.3 The kick payment shall be paid to the Contractor upon submission of satisfactory evidence of the occurrence of a delivery.

4.2.4 For deliveries occurring before thirty-nine (39) weeks without a medical indication (early elective deliveries), the amount of the kick payment shall be determined by LDH's actuary.

4.3 MCO Payment Schedule

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

4.3.2 LDH reserves the right to defer remittance of the monthly capitated payment scheduled for June until the first payment cycle in July to comply with State fiscal policies and procedures.

4.3.3 Any incentive payments made by LDH shall be made in accordance with the timeline established in Approved Incentive Arrangements and the MCIP protocol.

4.4 Financial Incentives for MCO Performance

4.4.1 MCO Performance Withhold Amount

4.4.1.1 LDH shall withhold a portion of the Contractor's monthly capitated payments to incentivize quality, health outcomes, and value-based payments. The withhold amount shall be equal to two percent (2%) of the monthly capitated payments for integrated physical and behavioral health for all MCO enrollees, exclusive of maternity kick payments, payments under the Voluntary Managed Care Incentive Program, and the FMP component of the monthly capitated payments.

4.4.1.2 At least half of the total withhold amount shall be considered the Quality Withhold and applied to incentivize quality and health outcomes for enrollees. The remainder of the total withhold amount shall be considered the Value-Based Payment (VBP) Withhold and applied to incentivize the Contractor's use and expansion of VBP arrangements with providers. LDH shall notify the Contractor of the relative portions of the quality and VBP withholds no later than August 1 for the subsequent calendar year.

4.4.1.3 No interest shall be due to the Contractor on any sums withheld or retained under this Section.

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

4.4.2 Earning the Quality and Health Outcomes Withhold

4.4.2.1 For each measurement year, the Contractor may earn back the Quality Withhold for the measurement year based on its performance relative to incentive-based measures and targets as established by LDH and specified in Attachment G, prior to the start of the measurement year.

4.4.2.2 Targets for Healthcare Effectiveness Data and Information Set (HEDIS®) incentive-based measure scores will be equal to or above National Committee for Quality Assurance (NCQA) Quality Compass Medicaid MCO National fiftieth (50^{th}) percentile values for the prior measurement year.

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

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

4.4.2.5 LDH shall determine the amount of the Quality Withhold earned back by the Contractor based on the Contractor's performance on the incentive-based measures.

4.4.2.6 All incentive-based measures shall be weighted equally for purposes of the Contractor earning back the Quality Withhold, unless otherwise specified by LDH prior to the measurement year.

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

4.4.2.8 If the Contractor submits its HEDIS results to NCQA per the timelines and specifications as required in the *Quality Management and Quality Improvement* section, along with proof of submission to LDH, LDH shall refund up to five (5) months of the Contractor's estimated withheld funds for quality and health outcomes for the measurement year for which the results are reported, provided that the unaudited results indicate that the Contractor is meeting or exceeding the benchmark or performance improvement targets for more than half of the IB measures.

4.4.2.9 Non-HEDIS incentive-based measure scores shall be calculated by LDH and compared to targets established by LDH.

4.4.2.10 For all measures, the Contractor's results shall be validated by LDH's contracted External Quality Review Organization and Outcomes Research & Evaluation Contractor.

4.4.2.11 No later than the end of the calendar year of the reporting year, LDH shall notify the Contractor of the amount of its Quality Withhold earned back and refund the amount within thirty (30) calendar days of such notice.

4.4.2.12 LDH shall retain the amount of the Quality Withhold not earned back by the Contractor.

4.4.3 Earning the VBP Withhold

For each Contract year, the Contractor may earn back the VBP Withhold based on its reporting and performance relative to VBP requirements and targets as established by this Contract and LDH as described in the *Value-Based Payment* section.

4.4.3.1 Earning the VBP Withhold for CY2020 (Contract Year One)

The Contractor has three (3) opportunities to earn a portion of the VBP Withhold back for each Contract Year. For performance related to CY2020, the Contractor shall meet all of the following VBP Withhold requirements to earn its withheld funds:

4.4.3.1.1 By March 1, 2020, the Contractor shall submit a multi-year VBP Strategic Plan consistent with the Contractor's Proposal and feedback from LDH during the readiness review. The Contractor's VBP Strategic Plan shall be in a format specified by LDH and include the Contractor's projected VBP baseline for CY2020 and expected VBP increases in CY2021 and CY2022.

4.4.3.1.1.1 If LDH determines that the Contractor has successfully completed this deliverable, LDH shall release the VBP withheld funds estimated to be equal to two (2) months of the VBP Withhold in CY2020.

4.4.3.1.2 By November 1, 2020, the Contractor shall submit a summary report on its VBP progress to date in a format specified by LDH as required in the *Value-Based Payment* section.

4.4.3.1.2.1 If LDH determines that the Contractor has successfully completed this deliverable, LDH shall release the VBP withheld funds estimated to be equal to three (3) months of the VBP Withhold in CY2020.

4.4.3.1.3 By July 1, 2021, the Contractor shall report on its VBP use as specified in the **MCO Manual***,* and attain a VBP rate that meets or exceeds LDH requirements for minimum VBP threshold as specified in this Contract.

4.4.3.1.3.1 If LDH determines that the Contractor has successfully completed this deliverable, LDH shall release all of the Contractor's remaining VBP withheld funds from CY2020.

4.4.3.2 Subsequent Year VBP Withhold Requirements

For each Contract Year after 2020, the Contractor shall meet all of the following VBP Withhold requirements to earn its withheld VBP funds:

4.4.3.2.1 By March 1, the Contractor shall update its multi-year VBP Strategic Plan consistent with its VBP activities to date and this Contract. The Contractor's updated VBP Strategic Plan shall be in a format specified by LDH and include the Contractor's VBP baseline for CY2020 and expected VBP increases in each subsequent year.

4.4.3.2.1.1 If LDH determines that the Contractor has successfully completed this deliverable, LDH shall release the VBP withheld funds estimated to be equal to two (2) months of the VBP Withhold in the Contract Year.

4.4.3.2.2 By November 1, the Contractor shall submit a summary report on its VBP progress to date in a format specified by LDH including data on the number of providers engaged in qualified VBP contractual arrangements and the percentage of enrollees attributed to primary care provider entities participating in such VBP arrangements and the Contractor's VBP plans in accordance with the Contractor's VBP Strategic Plan and this Contract.

4.4.3.2.2.1 If LDH determines that the Contractor has successfully completed this deliverable, LDH shall release the VBP withheld funds estimated to be equal to three (3) months of the VBP Withhold in the Contract Year.

4.4.3.2.3 By July 1, of the subsequent calendar year, the Contractor shall report on its VBP use as specified in the **MCO Manual**, and attain a VBP rate that meets or exceeds LDH requirements for the minimum VBP threshold as specified in this Contract.

4.4.3.2.3.1 If LDH determines that the Contractor has successfully completed this deliverable, LDH shall release all of the Contractor's remaining VBP withheld funds from the applicable Contract Year.

4.4.3.3 LDH shall retain the amount of the VBP Withhold not earned back by the Contractor.

4.5 Medical Loss Ratio

4.5.1 In accordance with the **MCO Manual**, the Contractor shall provide an annual Medical Loss Ratio (MLR) report following the end of the MLR reporting year.

4.5.2 The MLR shall be reported in the aggregate, including all medical services covered under the Contract.

4.5.2.1 If the aggregate MLR (cost for health care benefits and services and specified quality expenditures) is less than eighty-five percent (85%), the Contractor 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.

4.5.3 LDH may request MLR reporting that distinguishes physical and basic behavioral health from specialized behavioral health.

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

4.6 Payment Adjustments

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

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

4.6.3 If the enrollee's aid category and/or type case changed from MCO eligible to MCO excluded, previous capitation payments for excluded months will be recouped from the Contractor. The Contractor shall initiate recoupments of payments to providers within sixty (60) calendar days of the date LDH notifies the Contractor of the change. The Contractor shall instruct the provider to resubmit the claim(s) to the Medicaid FFS program (if applicable).

4.6.4 In cases of a retroactive effective date for Medicare enrollment of an enrollee, the Contractor shall recoup payments made to the providers. The Contractor shall initiate

recoupments within sixty (60) calendar days of the date LDH notifies the Contractor of Medicare enrollment. The Contractor shall instruct the provider to resubmit the claim(s) to Medicare and the payer with financial responsibility for the claim(s) (if applicable).

4.6.5 The Contractor shall refund payments received from LDH for a deceased enrollee after the month of death and an incarcerated enrollee the month after entering involuntary custody. LDH shall recoup the payment as specified in the Contract.

4.6.6 For enrollees dis-enrolled due to the invalidation of a duplicate Medicaid ID, the Contractor shall not recover claim payments under the retroactively dis-enrolled enrollee's ID if the remaining valid ID is linked to another MCO or FFS. The MCO shall subrogate to the MCO that is responsible for the claim(s) for the dates of service.

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

4.7 Risk Sharing

4.7.1 The Contractor shall agree to accept, as payment in full, the actuarially sound capitation rate and maternity kick payment established by LDH pursuant to the Contract, and shall not seek additional payment from an enrollee, or LDH, for any unpaid cost except as allowed by the cost sharing requirements of this Section.

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

4.8 Determination of MCO Rates

4.8.1 LDH shall develop actuarially sound capitation rates according to all applicable CMS rules and regulations. LDH shall not use a competitive bidding process to develop the MCO capitation. LDH shall develop monthly capitation rates that will be offered to MCOs. The monthly capitation rates are not negotiable.

4.8.2 Rates shall be set using FFS claims data, encounter data, and financial data and supplemental ad hoc data and analyses appropriate for determining actuarially sound capitation rates. Fiscal periods of the base data shall be determined based upon the data sources, rate periods and purposes for which the data is used with appropriate adjustments which include the following:

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

4.8.2.2 Unit cost trend and assumptions regarding managed care pricing and payments;

4.8.2.3 Third Party Liability recoveries; and

4.8.2.4 The expected cost of MCO administration and overhead, including but not limited to premium taxes.

4.8.3 LDH reserves the right to adjust the rate in the following instances:

4.8.3.1 Changes to MCO covered services included in the monthly capitation rates;

4.8.3.2 Changes to Medicaid population groups eligible to enroll in an MCO;

4.8.3.3 Legislative appropriations and budgetary constraints; or

4.8.3.4 Changes in federal requirements.

4.8.4 Any adjusted rate shall continue to be actuarially sound and consistent with requirements set forth in 42 C.F.R. §438.4 through §438.7, and will require an amendment to the Contract that is mutually agreed upon by both parties.

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

4.8.6 If FFS data is no longer available in the future, there shall be increasing reliance on encounter data and/or financial data to set future rates, subject to comparable adjustments.

4.8.7 The Contractor shall be paid in accordance with the monthly capitated rates specified in Attachment F, *Actuarial Rate Certification Letter* of this Contract.

4.8.8 The rates shall be reviewed and may be periodically adjusted. Any adjusted rates shall be actuarially sound and consistent with requirements set forth in 42 C.F.R. §438.4 through §438.7.

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

4.8.10 LDH shall utilize MCO overpayment and recovery data in calculating future capitation rates per 42 C.F.R. §438.608(d)(4).

4.9 Risk Adjustment

4.9.1 Capitated payments for integrated physical and behavioral health shall be risk-adjusted as deemed appropriate by LDH.

4.9.1.1 LDH shall analyze the risk profile of enrollees in each MCO using a national risk adjustment model specified by the State.

4.9.1.2 Each enrollee shall be assigned to risk categories based on factors appropriate for the risk adjustment model. This information and the relative cost associated with each risk category reflects the anticipated utilization of health care services relative to the overall population.

4.9.1.2.1 The relative costs shall be developed using Louisiana specific historical data from Medicaid FFS claims and encounter data as determined appropriate.

4.9.1.3 The relevant portions of each MCO's proposed base capitation rates shall be risk adjusted based on the MCO's risk score that reflects the expected health care expenditures associated with its enrollees relative to the applicable total Medicaid population.

4.9.1.4 LDH intends to develop risk adjustment scores that will be used for the first quarter to account for the initial MCO enrollment. The MCO risk adjustment scores will be updated for the second quarter by using enrollment near the end of the open enrollment process, which includes the period during which enrollees may change MCOs without cause. Following these two quarters, LDH intends to update the MCO risk scores semi-annually. This schedule may be revised if it is determined necessary by LDH.

4.9.1.5 Where practical, LDH shall notify the MCOs in advance of any major revision to the risk adjustment methodology that differs from the methodology used for the prior risk adjustment update. The MCO shall be given fourteen (14) calendar days to provide input on the proposed changes. LDH shall consider the feedback from the MCOs in the changes to the risk adjustment methodology.

4.9.2 Certain capitated payments may not be risk-adjusted based on considerations of how such payments were developed and the availability of risk adjustment data.

4.10 Return of Funds

4.10.1 All amounts owed by the Contractor to LDH, as identified through routine or investigative reviews of records or audits conducted by LDH or other state or federal agency, as well as monetary penalties levied against the Contractor for Contract non-compliance may be deducted from the monthly capitation payment upon notification by LDH.

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

4.11 Other Payment Terms

4.11.1 The Contractor shall make payments to its providers as stipulated in the Contract.

4.11.2 The Contractor shall not assign its right to receive payment to any other entity without written consent of LDH and the Commissioner of Administration.

4.11.3 Payment for items or services provided under this Contract will not be made to any entity located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and U.S. territories.

4.11.4 The Contractor 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 Contractor.

4.12 Cost Sharing

4.12.1 The Contractor and its subcontractors are not required to impose any copay or cost sharing requirements on their enrollees.

4.12.2 The Contractor and its subcontractors may impose cost sharing on Medicaid enrollees in accordance with 42 C.F.R. §447.50 through §447.57 provided that it does not exceed cost sharing amounts in the Louisiana Medicaid State Plan.

4.12.3 LDH reserves the right to amend cost sharing requirements.

4.12.4 The Contractor and its subcontractors may not:

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

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

4.12.4.3 Impose copayments for services specified in the **MCO Manual**.

4.13 Third Party Liability (TPL)

4.13.1 General TPL Information

4.13.1.1 Pursuant to federal and state law, the Medicaid program by law is intended to be the payer of last resort. This means all other available Third Party Liability (TPL) resources must meet their legal obligation to pay claims before the Contractor pays for the care of an individual eligible for Medicaid.

4.13.1.2 The Contractor shall take reasonable measures to determine TPL.

4.13.1.3 The Contractor shall coordinate benefits in accordance with 42 C.F.R. Part 433, Subpart D and La. R.S. 46:460.71, so that costs for services otherwise payable by the Contractor are cost avoided or recovered from a liable party. The two methods used are cost avoidance and post-payment recovery. The Contractor shall use these methods as described in federal and state law.

4.13.1.4 Establishing TPL takes place when the Contractor receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a health care item or services delivered to an enrollee.

4.13.1.5 If the probable existence of TPL cannot be established, the Contractor shall adjudicate the claim. The Contractor shall then utilize post-payment recovery if TPL is later determined to exist.

4.13.1.6 The Contractor may utilize subcontractors to comply with coordination of benefit (COB) efforts for services provided pursuant to this Contract. If the Contractor intends to subcontract for COB TPL services or with a subrogation vendor to perform its accident/trauma-related recoveries, the Contractor shall notify LDH of the vendor and provide a copy of the contract during readiness reviews. The Contractor shall notify LDH of any subsequent changes to its vendor and provide a copy of the contract no later than thirty (30) calendar days prior to the effective date of the contract. Failure to comply may result in monetary penalties being assessed against the Contractor.

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

4.13.1.8 The Contractor shall update its system with daily TPL records sent from LDH (or its contractor) within one (1) business day of receipt. The Contractor shall reconcile its system with weekly TPL reconciliation files sent from LDH within one (1) business day of receipt. If an enrollee is unable to access services or treatment until an update is made, the Contractor shall verify and update its system within four (4) business hours of receipt of an update request. This includes updates on coverage, including removal of coverage that existed prior to the enrollee's linkage to the Contractor that impacts current provider adjudication or enrollee service access. Such updates shall be submitted to LDH and/or its Third Party Liability vendor in the manner specified in the **MCO Manual**.

4.13.1.9 The Contractor shall review daily response files from LDH (or its contractor) and rejected records shall be corrected and completed within five (5) business days. The Contractor shall ensure its records reconcile to the weekly TPL reconciliation files received from LDH or its contractor. Failure to comply may result in monetary penalties in accordance with Attachment E.

4.13.1.10 Third Party Liability (TPL) Data Exchange

4.13.1.10.1 The Contractor shall:

4.13.1.10.1.1 Receive, process and update all records included in TPL files sent by LDH or its contractor;

4.13.1.10.1.2 Update its TPL databases within one (1) business day of receipt of said files; and

4.13.1.10.1.3 Transmit to LDH or its contractor, in the formats and methods specified by LDH, TPL files it or its TPL contractor discovers for each enrollee that has not otherwise been provided by LDH or its contractor.

4.13.2 Cost Avoidance and Pay and Chase

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

4.13.2.2 The Contractor shall "pay and chase" the full amount allowed under its payment schedule for the claim and then seek reimbursement from the TPL insurer. The Contractor shall within sixty (60) calendar days after the end of the month in which the payment was made (or within sixty (60) days after the end of the month the Contractor learns of the existence of a liable third party) pursue recovery from said third party for any legal liability.

4.13.3 Post-payment Recoveries

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

4.13.3.1.1 Initiate recovery of reimbursement within sixty (60) calendar days after the end of the month during which it learns of the existence of liable third parties after a claim is paid. This also includes claims which are classified as pay and chase.

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

4.13.3.1.3 If the liable third party is traditional Medicare, Tricare or Champus, and more than ten (10) months have passed since the DOS, the Contractor shall recover from the provider.

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

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

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

4.13.3.1.7 Inform providers they shall not send a refund check or initiate a void or adjustment request on post payment recovery claims. The Contractor shall initiate an automatic recoupment at the expiration of the sixty (60) day time period if an extension request is not received from the provider and at the expiration of the ninety (90) day time period if an extension is requested by the provider.

4.13.3.2 The Contractor shall void encounters for claims for which the full Medicaid paid amount is being recouped. For recoupments for which the full Medicaid paid amount is not being recouped, the Contractor shall submit adjusted encounters for the claims.

4.13.3.3 The Contractor shall identify the existence of potential TPL to pay for MCO covered services through the use of trauma code edits in accordance with 42 C.F.R. §433.138(e).

4.13.3.4 The Contractor shall be required to seek reimbursement in accident/trauma related cases when claims in the aggregate equal or exceed five hundred dollars ($500.00) as required by the Louisiana Medicaid State Plan and federal Medicaid guidelines and may seek reimbursement when claims in the aggregate are less than five hundred dollars ($500.00). Failure to seek reimbursement may result in monetary penalties as specified in Attachment E.

4.13.3.5 The Contractor shall notify LDH when subpoenas for legal proceedings are received and report the resulting recoveries to LDH.

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

4.13.3.7 Prior to accepting a TPL settlement on accident/trauma-related claims equal to or greater than twenty-five thousand dollars ($25,000.00), the Contractor shall obtain approval from LDH.

4.13.3.8 Upon receipt of a subpoena duces tecum, the Contractor shall produce documents responsive to said subpoena by the date of return indicated therein (or shall contact the party who caused issuance of the subpoena, in order to request additional time to respond) if the production is authorized under La. R.S. 13:3715.1. Upon receipt of a request for records not sent via subpoena, the Contractor shall release PHI or a response explaining why PHI cannot be released to the individual or entity making the request, within fifteen (15) calendar days of receipt of the request and a written authorization, as set forth in La. R.S. 40:1165.1(A)(2)(c). The Contractor is solely

responsible for any sanctions and costs imposed by a court for competent jurisdiction for failure to comply with the requirements of La. R.S. 40:1165.1(A)(2)(c) or for failure to respond timely to a subpoena duces tecum. Additionally, LDH may impose sanctions against the Contractor for failure to properly or timely respond to requests for PHI.

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

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

4.13.4 Distribution of TPL Recoveries

4.13.4.1 The Contractor may retain up to one hundred (100%) of its TPL collections if all of the following conditions exist:

4.13.4.1.1 Total collections received do not exceed the total amount of the Contractor's financial liability for the enrollee;

4.13.4.1.2 There are no payments made by LDH related to FFS, reinsurance or administrative costs (e.g., lien filing) for the enrollee;

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

4.13.4.1.4 LDH shall utilize the data in calculating future capitation rates.

4.13.5 TPL Reporting Requirements

4.13.5.1 The Contractor shall provide LDH TPL information in a format and medium described in the **MCO Manual** and shall cooperate in any manner necessary, as requested by LDH, with LDH and/or a cost recovery vendor of LDH.

4.13.5.2 The Contractor shall include the collections and claims information in the encounter data submitted to LDH, including any retrospective findings via encounter adjustments or voids.

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

4.13.5.4 Upon the request of LDH, the Contractor shall demonstrate that reasonable effort has been made to seek, collect and/or report TPL 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. Failure to seek reimbursement/recovery may result in monetary penalties as defined in Attachment E.

4.13.5.5 The Contractor shall 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.

4.13.6 LDH Right to Conduct Identification and Pursuit of TPL

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

4.13.6.2 If LDH determines that the Contractor is not actively engaged in cost avoidance activities, the Contractor may be subject to monetary penalties as defined in Attachment E.

4.14 Coordination of Benefits

4.14.1 Other Coverage Information

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

4.14.2 Reporting and Tracking

The Contractor's system shall identify and track potential collections. The system shall produce reports indicating open receivables, closed receivables, amounts collected, amounts written off and amounts avoided.

4.15 Financial Disclosures for Pharmacy Services

The Contractor shall disclose all financial terms and arrangements for remuneration of any kind that apply between the MCO or the MCO's PBM subcontractor and any prescription drug wholesaler, manufacturer or labeler, including, without limitation, formulary management, educational support, claims processing, pharmacy network fees, drug product sales or pricing agreements, data sales fees, and any other fees. The *Claims Management* section of this Contract provides that LDH or state auditors may audit such information at any time. LDH agrees to maintain the confidentiality of information disclosed by the MCO pursuant to the Contract, to the extent that such information is confidential under Louisiana or federal law.

4.16 Health Insurance Provider Fee (HIPF) Reimbursement

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

4.16.1 The Contractor shall, at a minimum, be responsible for adhering to the following criteria and reporting requirements:

4.16.1.1 Provide LDH with a copy of the final Form 8963 submitted to the IRS by the deadline to be identified by LDH each year. The Contractor shall provide LDH with any adjusted Form 8963 filings to the IRS within five (5) business days of any amended filing.

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

4.16.1.3 If the Contractor's Louisiana-specific Medicaid/CHIP premium revenue is not delineated on its Form 8963, provide with its Form 8963 a supplemental delineation of Louisiana-specific Medicaid/CHIP premium revenue that was listed on the MCO's Form 8963 and a methodological description of how its Louisiana-specific Medicaid/CHIP premium revenue (payments to the MCO pursuant to this Contract) was determined. The Contractor shall indicate for LDH the portion of the Louisiana-specific Medicaid/CHIP premiums that were excluded from the Form 8963 premiums

by the Contractor as Medicaid long-term care, if applicable, beginning with Data Year 2019.

4.16.1.3.1 The Contractor shall also submit a certification regarding the supplemental delineation consistent with 42 C.F.R. §438.604 and 42 C.F.R. §438.606.

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

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

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

4.16.1.6 Provide LDH with the corporate income tax rates – federal and state (if applicable) -- by the deadlines to be identified by LDH each year and include a certification regarding the corporate income tax rates consistent with 42 C.F.R. §438.604 and 42 C.F.R. §438.606.

4.16.1.7 Provide LDH with any additional HIPF supporting documentation upon request.

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

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

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

4.16.5 The Contractor shall advise LDH if payment of the final fee payment is less than the amount invoiced by the IRS.

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

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

4.16.8 The obligation outlined in this section shall survive the termination of the Contract.

4.17 Responsibility for Payment for Specialized Behavioral Health Services Provided to Coordinated System of Care (CSoC) Enrollees

4.17.1 The CSoC Contractor shall be responsible for payment to enrolled providers for the provision of specialized behavioral health services, with the exception of PRTF, TGH and SUD Residential treatment services (ASAM 3.1, 3.2-wm, 3.5 and 3.7 for children under 21 and Levels 3.3 and 3.7-wm for youth aged 21), for each month during which the enrollee has a 1915(c)/1915(b)(3) waiver segment on the eligibility file with a begin date on or earlier than the first day of that month, or in the event that an enrollee transfers between waivers during the month, but the previous segment began on or earlier than the first day of that month.

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

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

4.17.4 The Contractor shall be responsible for payment of all PRTF, TGH, and SUD Residential treatment services (ASAM Levels 3.1, 3.2-wm, 3.5 and 3.7 for children under 21 and Levels 3.3 and 3.7-wm for youth aged 21) for CSoC enrolled youth.

4.17.5 If a CSoC enrolled youth no longer meets medical necessity criteria for a higher level of service (e.g. inpatient hospital) that was authorized by the CSoC Contractor, and the MCO has authorized PRTF, TGH, or SUD Residential treatment services (ASAM Levels 3.1, 3.2-wm, 3.5 and 3.7), but is unable to secure placement, the MCO shall be responsible for assuming the continued authorization of, and payment for, the higher level service until placement is made, regardless of the youth's CSoC enrollment status.

4.18 Bond Requirements

4.18.1 Performance Bond

4.18.1.1 The Contractor shall establish and maintain a performance bond for the entire term of the Contract and continue to maintain the bond for at least fifteen (15) months following the termination date of this Contract or as long as the Contractor has Contract-related outstanding liabilities of at least fifty thousand dollars ($50,000.00), whichever is later, to guarantee: (1) payment of the Contractor's obligations to LDH

and (2) performance by the Contractor of its obligations under this Contract (42 C.F.R. §438.116).

4.18.1.2 The bond shall be obtained from an agent appearing on the United States Department of Treasury's list of approved sureties. The bond shall be made payable to the State of Louisiana. The Contract and dates of performance shall be specified in the bond.

4.18.1.3 The initial amount of the bond shall be equal to fifty (50) million dollars. The initial bond shall be submitted to LDH within ten (10) calendar days of Contract approval by the Office of State Procurement.

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

4.18.1.5 All bonds submitted to LDH shall be original and have the raised engraved seal on the bond and on the Power of Attorney page. The Contractor shall retain a photocopy of the bond.

4.18.1.6 Any performance bond furnished shall be written by a surety or insurance company currently on the U.S. Department of the Treasury Financial Management Service list of approved bonding companies which is published annually in the Federal Register, or by a Louisiana domiciled insurance company with at least an A-rating in the latest printing of the A.M. Best's Key Rating Guide to write individual bonds up to ten 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.

4.18.2 Fidelity Bond

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

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

PART 5: TURNOVER REQUIREMENTS

5.1 General Turnover Requirements

In the event of Contract termination initiated by LDH or the Contractor, expiration, or non-renewal, the Contractor shall:

5.1.1 Comply with all terms and conditions stipulated in the Contract, including continuation of MCO covered services under the Contract, until the termination effective date;

5.1.2 Promptly supply all information necessary for the reimbursement of any outstanding claims;

5.1.3 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;

5.1.4 Provide all reasonably necessary assistance to LDH in transitioning enrollees out of the Contractor's plan upon expiration of the Contract or to the extent specified in the notice of termination. Such assistance shall include the forwarding of medical and other records; facilitation and scheduling of medically necessary appointments for care and services; and identification of enrollees with special health care needs including those that are chronically ill, high risk, hospitalized or pregnant; and

5.1.5 Identify and maintain sufficient key personnel and support staff based in Louisiana to support all required Contract functions. The Contractor's transition team shall assist with enrollee transitions to a new MCO and ensure the sharing of documentation such as active prior authorizations, current assessments and care plans, and other necessary information to support continuity of care, particularly for enrollees with special health care needs.

5.2 Turnover Plan

5.2.1 Upon written notification of termination of the Contract by either party, the Contractor 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 Contractor and LDH. If the Contract is not terminated by written notification, the Contractor shall propose a Turnover Plan six (6) months prior to the end of the Contract period, including any extensions to such period.

5.2.2 The Turnover Plan shall:

5.2.2.1 Be approved by LDH;

5.2.2.2 Detail the proposed schedule, activities, and resource requirements associated with the turnover tasks;

5.2.2.3 Address the turnover of records and information maintained by the Contractor to either LDH or a third party designated by LDH;

5.2.2.4 Describe the Contractor's approach for the transfer of all records, data, and operational support information, as applicable, to either LDH or a third party designated by LDH; and

5.2.2.5 Include copies of all relevant enrollee and covered services data, documentation, or other pertinent information necessary, as determined by LDH, for LDH or a subsequent MCO to assume the operational activities successfully. This includes correspondence, documentation of ongoing outstanding issues, and other operations support documentation.

5.3 Transfer of Data

5.3.1 The Contractor shall transfer all data regarding the provision of enrollee covered services to LDH or a third party, at the sole discretion of LDH and as directed by LDH. All transferred data must be transferred in compliance with HIPAA.

5.3.2 All required transfers of data and information specified in this Contract shall be made electronically, unless otherwise directed by LDH, and according to the format and schedule approved by LDH.

5.3.3 All relevant data shall be received and verified by LDH or the subsequent MCO. If LDH determines that not all of the data regarding the provision of covered services to enrollees was transferred to LDH or the subsequent MCO, as required, or the data was not transferred in a HIPAA compliant manner, 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 was transferred in a HIPAA compliant manner. Payment of the reasonable costs incurred for providing these services shall be the responsibility of the Contractor.

5.4 Post-Turnover Services

5.4.1 Thirty (30) calendar days following turnover of operations, the Contractor shall provide LDH with a Turnover Results report documenting the completion and results of each step of the Turnover Plan. Turnover shall not be considered complete until this document has been approved by LDH.

5.4.2 If the Contractor does not provide the required relevant data and reference tables, documentation, or other pertinent information necessary for LDH or the subsequent MCO to assume the operational activities successfully, the Contractor 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 Contractor shall also pay any and all additional costs incurred by LDH that are the result of the Contractor's failure to provide the requested records, data or documentation within the time frames agreed to in the Turnover Plan.

5.4.4 The Contractor shall maintain all files and records related to enrollees and providers for ten (10) years after the date of final payment under the Contract or until the resolution of all

litigation, claims, financial management review or audit pertaining to the Contract, whichever is longer. Under no circumstances shall the Contractor or any of its material subcontractors destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

5.4.5 The Contractor agrees to repay any valid, undisputed audit exceptions taken by LDH in any audit of the Contract.

5.5 Transition to Managed Long-Term Supports and Services

5.5.1 Should the State enter into a managed care contract to offer holistic health care to dual eligible enrollees and/or enrollees requiring long-term supports and services, the Contractor shall cooperate with any transition of populations or services to other health care delivery systems and/or contractors.

5.5.2 The Contractor shall be responsible for coordinating with the new contractor for any records or service management data required for the transition of enrollees and services to and from the new contractor's systems and care management.

5.5.3 Transitions may result in the loss of Per Member Per Month (PMPM) payments to the Contractor for enrollees transitioning out of the MCO into the new system of care for long-term supports and services and may result in adjustments to the monthly capitated rate in order to maintain actuarial soundness.

5.5.4 The Contractor shall adhere to all transition requirements provided by LDH upon implementation of any new managed care contract(s).

PART 6: TERMS AND CONDITIONS

6.1 General Terms

The Contract execution date is anticipated to be June 30, 2019, and the operational start date is anticipated to be January 1, 2020. LDH reserves the right to revise the anticipated operational start date and shall provide the Contractor sixty (60) calendar days' prior notice of such change. The Contractor shall successfully complete a readiness review as specified in the *Contract Transition and Readiness* section of this Contract prior to the operational start date in the time frame specified by LDH. If the Contractor does not pass the readiness review, the Contract shall be terminated by LDH.

The term of the Contract shall be thirty-six (36) months from the operational start date unless terminated prior to that date in accordance with state or federal law or terms of the Contract. With approval from the Joint Legislative Committee on the Budget (JLCB), if applicable, LDH may exercise an option to extend the Contract up to twenty-four (24) additional months at the same rates, terms, and conditions inclusive of any and all amendments thereto.

The Contractor agrees to comply with all state and federal laws, rules and policies, the State Plan, and waivers as applicable to this Contract, including those in the LDH Standard Contract Form (CF-1). Any provision of this Contract that is in conflict with federal statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal policy. Such amendment of the Contract shall be effective on the effective date of the statutes, regulations, or policy statement necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties. The Contractor may request LDH to make policy determinations required for proper performance of the services under this Contract.

6.2 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 period, to ensure the smooth operations of the Medicaid managed care program. Such clarifications shall be implemented by the MCO and shall not require an amendment to the Contract.

6.3 Applicable Laws and Regulations

The Contractor agrees to comply with all applicable federal and state laws, regulations, and rules, including Constitutional provisions regarding due process and equal protection, and including, but not limited to:

6.3.1 Code of Federal Regulations (C.F.R.), Title 42, Chapter IV, Subchapter C (Medical Assistance Programs);

6.3.2 All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 (42 U.S.C. §7401, et seq.), the Clean Water Act (33 U.S.C. §1251 et seq.), and 20 U.S.C. §6081, et seq. of the Pro-Children Act of 1994 (P.L. 103-227);

6.3.3 42 C.F.R. §438.100(a)(2), which requires the Contractor to comply with any applicable federal and state laws that pertain to enrollee rights and ensure that its employees and contracted providers observe and protect those rights.

6.3.4 Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d, et seq.) and regulations issued pursuant thereto, 45 C.F.R. Part 80. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d, et seq.) and its implementing regulations at 45 C.F.R. Part 80, the Contractor shall take adequate steps to ensure that persons with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Contract;

6.3.5 Title VII of the Civil Rights Act of 1964 (42 U.S.C. §2000e, et seq.) in regard to employees or applicants for employment;

6.3.6 Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 C.F.R. Part 84;

6.3.7 The Age Discrimination Act of 1975, 42 U.S.C. §6101 et seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance;

6.3.8 The Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance;

6.3.9 The Balanced Budget Act of 1997, P.L. 105-33 and the Balanced Budget Refinement Act of 1999, P.L. 106-113;

6.3.10 The Americans with Disabilities Act of 1990, 42 U.S.C. §12101 et seq., and regulations issued pursuant thereto;

6.3.11 Sections 1128 and 1156 of the Social Security Act, relating to exclusion of MCOs for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

6.3.12 The Drug Free Workplace Act of 1988, P.L. 100-690, as implemented in 2 C.F.R. Part 182;

6.3.13 Title IX of the Education Amendments of 1972, regarding education programs and activities;

6.3.14 The Byrd Anti-Lobbying Amendment regarding contractors who apply or bid shall file the required certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. §1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier-to-tier up to the recipient (45 C.F.R. Part 3);

6.3.15 The Equal Employment Opportunity Act of 1972;

6.3.16 Executive Order 11246;

6.3.17 The Rehabilitation Act of 1973;

6.3.18 The Vietnam Era Veterans' Readjustment Assistance Act of 1974;

6.3.19 The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (42 C.F.R. Parts 438, 440, 456 and 457), which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan;

6.3.20 Section 1557 of the Patient Protection and Affordable Care Act (ACA); and

6.3.21 Notwithstanding moral and religious objections in the *Services* section of this Contract, the Contractor agrees not to discriminate in its employment practices, and will render services under this Contract without regard to race, color, religion, sex, national origin, veteran status, political affiliation, or disabilities. Any act of discrimination committed by Contractor, or failure to comply with these statutory obligations when applicable shall be grounds for termination of this Contract.

6.4 Assessment of Fees

The Contractor and LDH agree that LDH may choose to deduct any assessed fees from payments due or owing to the Contractor or may direct the Contractor to make payment directly to LDH for any and all assessed fees. The choice is solely and strictly LDH's choice.

The Contractor 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.

6.5 Attorney Fees

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

expenses of such action including reasonable attorney 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.

6.6 Board Resolution/Signature Authority

The Contractor, if a corporation, shall secure and attach to the Contract a formal Board Resolution indicating the signatory to the Contract is a corporate representative and authorized to sign said Contract.

6.7 Civil Rights Compliance

The Contractor agrees to abide by 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 Veterans’ 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 Contractor agrees to abide by the requirements of the Americans with Disabilities Act of 1990.

The Contractor agrees not to discriminate in its employment practices, and will render services under this Contract without regard to race, color, religion, sex, sexual orientation, national origin, veteran status, political affiliation, disability, or age in any matter relating to employment. Any act of discrimination committed by the Contractor, or failure to comply with these statutory obligations when applicable shall be grounds for termination of this Contract.

6.8 Code of Ethics

The Contractor acknowledges that Chapter 15 of Title 42 of the Louisiana Revised Statutes (R.S. 42:1101 et seq., Code of Governmental Ethics) applies to the Contracting Party in the performance of services called for in this Contract. The Contractor agrees to immediately notify the State if potential violations of the Code of Governmental Ethics arise at any time during the term of this Contract.

6.9 Confidentiality of Information

6.9.1 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 this Contract, or which become available to the Contractor in carrying out this Contract, shall be protected by the Contractor from unauthorized use and disclosure through the observance of the same or more effective 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 this paragraph to keep confidential any data or information which is or becomes publicly available, is independently developed by the Contractor outside the scope of the Contract, or is rightfully obtained from third parties.

6.9.2 Under no circumstance shall the Contractor discuss and/or release information to the media concerning this project without prior express written approval of LDH.

6.9.3 The Contractor shall ensure that medical records and any and all other health and enrollment information relating to enrollees or potential enrollees, which is provided to or obtained by or through the MCO's performance under this Contract, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under 45 C.F.R. Parts 160 and 164 (the HIPAA Privacy Rule) and other state and federal laws, or this Contract. The Contractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Contract.

6.9.4 All information as to personal facts and circumstances concerning enrollees or potential enrollees obtained by the Contractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of LDH or the enrollee/potential enrollee, unless otherwise permitted by HIPAA or required by applicable State or federal law regulations, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning enrollees/potential enrollees shall be limited to purposes directly connected with the administration of this Contract.

6.10 Conflict of Interest

The Contractor may not contract with Louisiana Medicaid unless such safeguards at least equal to federal safeguards (41 U.S.C. §2102) are in place per State Medicaid Director Letter dated December 30, 1997 and Section 1932(d)(3) of the Social Security Act, addressing 1932 State Plan Amendment and the default enrollment process under the State Plan Amendment option.

6.11 Contract Controversies

Any claim or controversy arising out of the Contract shall be resolved by the provisions of La. R.S. 39:1672.1-1672.4.

6.12 Contract Language Interpretation

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

6.13 Cooperation with Other Contractors

6.13.1 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 and enrollment broker services, the Contractor agrees to cooperate fully with such other contractors. The Contractor shall not commit any act that will interfere with the performance of work by any other LDH contractor.

6.13.2 The Contractor's failure to cooperate and comply with this provision shall be sufficient grounds for LDH to halt all payments due or owing to the Contractor until it becomes compliant with this or any other Contract provision. LDH's determination on the matter shall be final and not subject to appeal.

6.14 Copyrights

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

6.15 Corporation Requirements

If the Contract is a corporation, the following requirement shall be met prior to execution of the Contract:

6.15.1 If a for profit corporation whose stock is not publicly traded, the Contractor must file a Disclosure of Ownership form with the Louisiana Secretary of State.

6.15.2 If the Contractor is a corporation not incorporated under the laws of the State of Louisiana, the Contractor shall obtain a Certificate of Authority pursuant to La. R.S. 12:301 et seq. from the Louisiana Secretary of State.

6.15.3 The Contractor shall provide written assurance to LDH from the Contractor's legal counsel that the Contractor is not prohibited by its articles of incorporation, bylaws or the laws under which it is incorporated from performing the services required under the Contract.

6.16 Debarment/Suspension/Exclusion

6.16.1 The Contractor agrees to comply with all applicable provisions of 2 C.F.R. Part 376, pertaining to nonprocurement debarment and/or suspension. As a condition of enrollment, the Contractor shall screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or all federal health care programs.

6.16.2 The Contractor shall conduct the screen monthly to capture exclusions and reinstatements that have occurred since the last search, and any exclusion information discovered should be immediately reported to LDH. Any individual or entity that employs or subcontracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even

when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against providers who employ or enter into provider agreements with excluded individuals or entities to provide items or services to enrollees. See 42 U.S.C. §1320a-7 and §1320a-7a and 42 C.F.R. §1003.102(a)(2).

6.17 Effect of Termination on Contractors HIPAA Privacy Requirements

6.17.1 Upon termination of this Contract for any reason, the Contractor shall return or destroy, as directed by LDH in writing, all PHI received from LDH, or created or received by the Contractor on behalf of LDH. This provision shall also apply to PHI that is in the possession of subcontractors or agents of the Contractor. The Contractor shall not retain any copies of PHI.

6.17.2 In the event that the Contractor determines that returning or destroying PHI is not feasible, the Contractor shall provide to LDH notification of the conditions that make return or destruction not feasible. Upon a mutual determination that return or destruction of PHI is not feasible, the Contractor shall extend the protections of the Contract to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction not feasible, for so long as the Contractor maintains such PHI.

6.18 Emergency Management Plan

6.18.1 The Contractor shall submit an Emergency Management Plan for approval as part of readiness reviews. The Emergency Management Plan shall specify actions the Contractor 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 Contractor shall submit an annual certification (from the date of the most recently approved plan) to LDH certifying that the Emergency Management Plan is unchanged from the previously approved plan.

6.18.2 The Contractor shall follow all LDH directives regarding access to care and relaxation of authorization requirements during an emergency. Corresponding system edits for all services, including pharmacy and medical or behavioral health, shall be implementable at the parish level during an emergency.

6.18.3 At a minimum, the plan shall include the elements contained in the **MCO Manual**.

6.19 Employee Education about False Claims Recovery

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

6.20 Employment of Personnel

6.20.1 In all hiring or employment made possible by or resulting from this Contract, the Contractor agrees that:

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

6.20.1.2 Affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all applicable state and federal laws regarding employment of personnel.

6.20.2 This requirement shall apply to, but not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training including apprenticeship. The Contractor further agrees to give public notice in conspicuous places available to employees and applicants for employment setting forth the provisions of this Section. All solicitations or advertisements for employees shall state that all qualified applicants will receive consideration for employment without regard to handicap, age, race, color, religion, sex, or national origin. All inquiries made to the Contractor concerning employment shall be answered without regard to handicap, age, race, color, religion, sex, or national origin. All responses to inquiries made to the Contractor concerning employment made possible as a result of this Contract shall conform to federal, state, and local regulations.

6.21 Entire Contract

This Contract, together with the RFP and any addenda issued thereto by LDH, the proposal submitted by the Contractor in response to LDH's RFP, and any attachments or exhibits specifically incorporated herein by reference constitute the entire agreement between the parties with respect to the subject matter.

The Contractor shall comply with all provisions of the Contract and shall act in good faith in the performance of the provisions of said Contract. The Contractor 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 therein. The Contractor shall comply with all applicable state and federal laws, rules, regulations, policies, the State Plan and waivers, and the **MCO Manual**.

LDH, at its discretion, may issue correspondence to inform the Contractor of changes in Medicaid policies and procedures which may affect the Contract. Unless otherwise specified in the Medicaid correspondence, the Contractor shall be given sixty (60) calendar days to implement such changes.

6.22 Force Majeure

The Contractor and LDH may be excused from performance under this Contract for any period they may be prevented from performance by an act of God, strike, war, civil disturbance, or court order. The Contractor shall, however, be responsible for the development and implementation of an Emergency Management Plan as specified in the *Emergency Management Plan s*ection of this Contract.

6.23 Governing Law and Place of Suit

It is mutually understood and agreed that this Contract shall be governed by the laws of the State of Louisiana, except its conflict of laws provisions, as to both interpretation and performance. Any administrative proceeding, action at law, suit in equity, or judicial proceeding for the enforcement of this Contract or any provision thereof shall be instituted only in the administrative tribunals and courts of the State of Louisiana. Specifically, any state court suit shall be filed in the 19th Judicial District Court for East Baton Rouge Parish as the exclusive venue for same, and any federal suit shall be filed in the U.S. District Court for the Middle District of Louisiana as the exclusive venue for same. This Section shall not be construed as granting a right or cause of action to the Contractor in any of the aforementioned Courts.

6.24 HIPAA Business Associate

Individually identifiable health information is to be protected in accordance with the rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as agreed upon in the **HIPAA Business Associate Addendum**.

6.25 Confidentiality Compliance

The Contractor shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (the HITECH Act) and the rules and regulations promulgated thereunder (45 C.F.R. Parts 160, 162, and 164). The Contractor shall ensure compliance with all HIPAA requirements across all systems and services related to this Contract, including transaction, common identifier, and privacy and security standards, by the effective date of those rules and regulations.

6.26 Confidentiality of Patient Records

The Contractor shall agree to comply with the requirements of 42 U.S.C. §290dd-2 and its implementing regulations, 42 C.F.R. Part 2. The Contractor shall also agree to strictly maintain the confidentiality of patient records of drug, alcohol, and other drug treatment programs in addition to treatment and assessment for pathological or compulsive gambling.

The Contractor shall ensure that every individual treated by a provider that is a covered “Part 2 program”, as defined in 42 C.F.R. §2.11, is offered the opportunity to sign a consent form for the disclosure of substance use treatment information to the individual’s PCP for the purpose of health care integration in accordance with 42 C.F.R. Part 2, Subpart C.

The Contractor shall have the ability to track provider compliance with offering consent forms for enrollees receiving substance use services from Part 2 programs, including the number of enrollees receiving substance use services by each provider and the number of consent forms offered and signed. The Contractor shall report this information to LDH upon request.

The Contractor shall educate contracted providers on protocols for requesting and receiving patient records in accordance with 45 C.F.R. Parts 160 and 164 (HIPAA) and 42 C.F.R. Part 2.

When substance use information is subject to the requirements of 42 C.F.R. Part 2, any disclosure of that information without the written consent of the patient shall comply with 42 C.F.R. Part 2 and shall be accompanied by a statement notifying the recipient of the prohibition against re-disclosure.

The Contractor shall develop policies and procedures which outline HIPAA requirements and 42 C.F.R. Part 2 requirements for the purpose of health care integration. These policies and procedures shall outline instances in which 42 C.F.R. Part 2 requirements override HIPAA requirements.

6.26.1 HIPAA Disclosure Process

6.26.1.1 The Contractor shall protect confidential information and documents in accordance with 42 U.S.C. §671(a)(8), 42 U.S.C. §5106a, 42 U.S.C. §290dd-2, 45 C.F.R. §1355.21, 45 C.F.R. §205.50, 45 C.F.R. §1355.30, 42 C.F.R. Part 2, La. R.S. 46:56, and 45 C.F.R. Parts 160 and 164, as applicable. The Contractor shall disclose in writing any use or disclosure of PHI other than as permitted by the Contract within three (3) calendar days of becoming aware of the use or disclosure.

6.26.1.2 The Contractor is required to submit incident reports affecting providers or enrollees receiving services to LDH with a corrective action plan and timelines for implementation of correction for approval by LDH within ten (10) business days of the Contractor's discovery of any HIPAA breaches, as defined at 45 C.F.R. §164.402. The incident report shall include, at a minimum:

6.26.1.2.1 Date of discovery;

6.26.1.2.2 Date or date range of violation/potential violation;

6.26.1.2.3 Cause of the incident including sequence and mechanisms;

6.26.1.2.4 Number of unauthorized individuals who viewed PHI;

6.26.1.2.5 Number of affected individuals whose PHI was compromised;

6.26.1.2.6 Steps taken to correct this incident to date, and planned steps to correct incident;

6.26.1.2.7 Steps taken to prevent reoccurrence from happening in the future;

6.26.1.2.8 Steps taken to mitigate any harmful effects caused by the unauthorized disclosure;

6.26.1.2.9 Any training or other corrective action targeted to the Contractor;

6.26.1.2.10 Staff or providers subsequent to this incident;

6.26.1.2.11 Plans for notification of CMS/HHS;

6.26.1.2.12 Notification plan to individuals; and

6.26.1.2.13 A risk assessment which includes the following:

6.26.1.2.13.1 The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;

6.26.1.2.13.2 The unauthorized person who used the PHI or to whom the disclosure was made;

6.26.1.2.13.3 Whether the PHI was actually acquired or viewed; and

6.26.1.2.13.4 The extent to which the risk to the PHI has been mitigated.

6.27 Hold Harmless

6.27.1 The Contractor shall indemnify, defend, protect, and hold harmless LDH and any of its officers, agents, and employees from:

6.27.1.1 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 MCO in connection with the performance of this Contract;

6.27.1.2 Any claims for damages or losses arising from sanctions on MCO network providers and enrollees, including, but not limited to, termination or exclusion from the network, in accordance with provisions in the *Fraud, Waste, and Abuse Prevention* Section.

6.27.1.3 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 the Contractor, its agents, officers, employees, or subcontractors in the performance of this Contract;

6.27.1.4 Any claims for damages or losses resulting to any person or firm injured or damaged by the Contractor, its agents, officers, employees, or subcontractors by the Contractor's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Contract in a manner not authorized by the Contract or by federal or state regulations or statutes;

6.27.1.5 Any claims for damages or losses arising from failure by the Contractor, its agents, officers, employees, or subcontractors to comply with applicable federal or state laws, including, but not limited to, state and federal Medicaid laws and regulations, labor laws and minimum wage laws, or to comply with any applicable consent decrees, settlements, or adverse judicial determinations;

6.27.1.6 Any claims for damages, losses, reasonable costs, or attorney fees, including, but not limited to, those incurred by or on behalf of LDH in connection with non-compliance with any judgment, settlement, court order, or consent decree, for which the responsibility for compliance has been delegated to the Contractor by LDH;

6.27.1.7 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

6.27.1.8 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 Contractor, its agents, officers, employees, or subcontractors.

6.27.2 In the event of circumstances not reasonably within the control of the Contractor or LDH, (e.g., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot, or civil insurrection), neither the Contractor, 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 the preceding, as long as this Contract remains in full force and effect, the Contractor shall be liable for the covered services required to be provided or arranged for in accordance with this Contract.

6.27.3 LDH shall provide prompt notice of any claim against it that is subject to indemnification by the Contractor. The Contractor 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 the Contractor, which shall not be unreasonably withheld.

6.28 Hold Harmless as to the MCO Enrollees

6.28.1 Notwithstanding State Plan approved cost sharing, the Contractor hereby agrees not to bill, charge, collect a deposit from, seek cost sharing or other forms of compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for health care services which are rendered to such enrollees by the Contractor and its subcontractors, and which are MCO covered services.

6.28.2 The Contractor further agrees that the enrollee shall not be held liable for payment for covered services furnished under a provider agreement, referral, or other arrangement, to the extent that those payments would be in excess of the amount that the enrollee would owe if the Contractor provided the service directly. The Contractor agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by the Contractor and insolvency of the Contractor.

6.28.3 The Contractor further agrees that the enrollee shall not be held liable for the costs of any and all services provided by a provider whose service is not covered by the Contractor or does not obtain timely approval or required prior-authorization.

6.28.4 The Contractor further agrees that this provision shall be construed to be for the benefit of the enrollees, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Contractor and its enrollees, or persons acting on their behalf.

6.29 Homeland Security Considerations

6.29.1 The Contractor shall perform the services to be provided under this Contract entirely within the United States. The term "United States" includes the fifty (50) states, the District of Columbia, and U.S. territories. In addition, the Contractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

6.29.2 If the Contractor performs services, or uses services, in violation of the foregoing paragraph, the Contractor shall be in material breach of this Contract and shall be liable to LDH for any costs, fees, damages, claims, or expenses it may incur. Additionally, the Contractor shall be required to hold harmless and indemnify LDH pursuant to the indemnification provisions of this Contract.

6.29.3 The prohibitions in this Section shall also apply to any and all agents and subcontractors used by the Contractor to perform any services under this Contract.

6.30 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 this Contract.

The 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 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 the Contractor's sole expense, and (iii) assistance in the defense of any such action at the expense of the Contractor. Where a dispute or claim arises relative to a real or anticipated infringement, the State or its Authorized Users may require the Contractor, at its sole expense, to submit such information and documentation, including formal patent attorney opinions, as the Commissioner of Administration shall require.

If the Contractor fails to provide records to LDH in accordance with the public records' request requirements in the *Administration & Contract Management* section, the Contractor shall indemnify, defend, protect, and hold harmless LDH and any of its officers, agents, and employees from any claims arising out of this failure, including, but not limited to, reasonable court costs and attorney fees.

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; or 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 the Contractor believes that it may be enjoined, the 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; (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 $100,000.00, 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.

6.31 Independent Provider

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

6.32 Insurance Requirements for Contractors

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.

6.32.1 Contractor's Insurance

The Contractor shall purchase and maintain for the duration of the Contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by the Contractor, its agents, representatives, employees or subcontractors. The cost of such insurance shall be included in the total Contract amount.

6.32.1.1 General Insurance Information

6.32.1.1.1 The Contractor shall not commence work under this Contract until it has obtained all insurance required herein. Certificates of Insurance, fully executed by officers of the insurance company shall be submitted to LDH for approval. The Contractor shall be named as the insured on the policy.

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

6.32.1.1.3 If so requested, the Contractor shall also submit copies of insurance policies for inspection and approval by LDH before work is commenced.

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

6.32.1.2 Minimum Scope and Limits of Insurance

6.32.1.2.1 Workers Compensation

6.32.1.2.1.1 Workers Compensation insurance shall be in compliance with the Workers Compensation law of the State of the Contractor's headquarters. Employers Liability is included with a minimum limit of $1,000,000 per accident/per disease/per employee. If work is to be

performed over water and involves maritime exposure, applicable provisions of the Longshore and Harbor Workers' Compensation Act (LHWCA), The Merchant Marine Act of 1920 (Jones Act), or other maritime laws shall be included. A.M. Best's insurance company rating requirement may be waived for workers compensation coverage only.

6.32.1.2.2 Commercial General Liability

6.32.1.2.2.1 The Contractor shall maintain, during the life of the Contract, Commercial General Liability Insurance to protect the Contractor, LDH, and any subcontractor during the performance of work covered by the Contract from claims or damages for personal injury, including accidental death, as well as from claims for property damages, which may arise from operations under the Contract, whether such operations be by the Contractor or by a subcontractor, or by anyone directly or indirectly employed by either of them, or in such a manner as to impose liability to LDH.

6.32.1.2.2.2 In the absence of specific regulations, the amount of coverage shall be as follows: Commercial General Liability Insurance, including bodily injury, property damage and contractual liability, with a minimum limit per occurrence of $2,000,000 and a minimum general aggregate of $4,000,000.

6.32.1.2.3 Reinsurance

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

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

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

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

6.32.1.2.4 Professional Liability (Errors and Omissions)

Professional Liability (Error & Omissions) insurance, which covers the professional errors, acts, or omissions of the Contractor, shall have a minimum limit of $3,000,000. Claims-made coverage is acceptable. The date of the inception of the policy shall be no later than the first date of the anticipated work under this Contract. It shall provide coverage for the duration of this 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.

6.32.1.2.5 Automobile Liability

Automobile Liability Insurance shall have a minimum combined single limit per accident of $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.

6.32.1.2.6 Cyber Liability

Cyber liability insurance, including first-party costs, due to an electronic breach that compromises the State's confidential data shall have a minimum limit per occurrence of $3,000,000. Claims-made coverage is acceptable. The date of the inception of the policy shall be no later than the first date of the anticipated work under this Contract. It shall provide coverage for the duration of this 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.

6.32.1.3 Deductibles and Self-Insured Retentions

Any deductibles or self-insured retentions shall be declared to and accepted by the Agency. The Contractor shall be responsible for all deductibles and self-insured retentions.

6.32.1.4 Other Insurance Provisions

The policies are to contain, or be endorsed to contain, the following provisions:

6.32.1.4.1 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 the Agency.

The Contractor's insurance shall be primary with respect to 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 in excess and non-contributory of the Contractor's insurance.

6.32.1.4.2 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 the Agency.

6.32.1.4.3 All Coverages

6.32.1.4.3.1 All policies must be endorsed to require thirty (30) calendar days' written notice of cancellation to the Agency. Ten (10) calendar days' 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.

6.32.1.4.3.2 The acceptance of the completed work, payment, failure of the Agency to require proof of compliance, or Agency's acceptance of a non-compliant certificate of insurance shall not release the Contractor from the obligations of the insurance requirements or indemnification agreement.

6.32.1.4.3.3 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.

6.32.1.4.3.4 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.

6.32.1.5 Acceptability of Insurers

All required insurance shall be provided by a company or companies lawfully authorized to do business in the state of Louisiana. 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.

6.32.1.6 Verification of Coverage

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, 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, this 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.

6.32.1.7 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.

6.32.1.8 Workers Compensation Indemnity

In the event the Contractor is not required to provide or elects not to provide workers compensation coverage, the parties hereby agree that the 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 or employees as an employer, whether pursuant to the Louisiana Workers Compensation Law, La. R.S. 23:1020.1, et seq. 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 the Contractor, its owners, agents, and employees. The parties further agree that the Contractor is a wholly independent contractor and is exclusively responsible for its employees, owners, and agents. 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 this Contract.

6.33 Integration

This Contract and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. The Contractor also agrees to be bound by the Contract and any rules or regulations that may be promulgated. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or affect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved by the parties.

6.34 Interest

Interest generated through investments made by the Contractor shall be the property of the Contractor and shall be used at the Contractor's discretion.

6.35 Interpretation Dispute Resolution Procedure

6.35.1 The Contractor may request in writing an interpretation of the issues relating to the Contract from the Medicaid MCO Program Director. In the event the Contractor disputes the interpretation by the Medicaid MCO Program Director, the Contractor shall submit a written reconsideration request to the Medicaid Director.

6.35.2 The Contractor 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.

6.35.3 The Medicaid Director shall reduce the decision to writing and provide a copy to the Contractor. The written decision of the Medicaid Director shall be the final decision of LDH. The Medicaid Director will render his or her final decision based upon the written submission of the Contractor and the Medicaid MCO Program Director, unless, at the sole discretion of the Medicaid Director, the Medicaid Director allows an oral presentation by

the Contractor and the Medicaid MCO Program Director or his/her designee. If such a presentation is allowed, the information presented shall be considered in rendering the decision.

6.35.4 Pending final determination of any dispute over a LDH decision, the Contractor shall proceed diligently with the performance of the Contract and in accordance with the direction of LDH.

6.36 Loss of Federal Financial Participation (FFP)

The Contractor hereby agrees to be liable for any loss of FFP suffered by LDH due to the Contractor's, or its subcontractors', failure to perform the services as required under this Contract. Payments provided for under this Contract shall be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 C.F.R. §438.730. CMS may deny payment to the State for new enrollees if its determination is not timely contested by the Contractor.

6.37 Misuse of Symbols, Emblems, or Names in Reference to Medicaid

The Contractor may not use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems the words "Louisiana Medicaid" or "Department of Health" 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.

6.38 National Provider Identifier (NPI)

The HIPAA Standard Unique Health Identifier regulations (45 C.F.R. Part 162) require that all covered entities (health care clearinghouses and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES).

6.39 Non-Discrimination

In accordance with 42 C.F.R. §438.3(d)(3) and (4), the Contractor shall not discriminate against individuals eligible to enroll on the basis of health status or need for health care services or on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability. The Contractor shall also not discriminate on the basis of religion. The Contractor agrees that no person, on the grounds of these factors, shall be excluded from participation in, or be denied benefits of the Contractor's program, or be otherwise subjected to discrimination in the performance of this Contract. The Contractor shall not use any policy or practice, including its employment practices, that has the effect of discriminating on these factors. The Contractor shall

post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider agreements.

6.40 Non-Waiver of Breach

The failure of LDH at any time to require performance by the Contractor of any provision of this Contract, or the continued payment of the Contractor by LDH, shall in no way affect the right of LDH to enforce any provision of this Contract; nor shall the waiver of any breach of any provision thereof be taken or held to be a waiver of any succeeding breach of such provision or as a waiver of the provision itself. No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract shall be waived except by the written agreement of the parties and approval of CMS, if applicable. Waiver of any breach of any term or condition in this Contract shall not be deemed a waiver of any prior or subsequent breach. No term or condition of this Contract shall be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties hereto.

6.41 Offer of Gratuities

By signing this Contract, the Contractor signifies that no member of, or a delegate of, Congress, nor any elected or appointed official or employee of the State of Louisiana, the Government Accountability Office, DHHS, CMS, or any other federal agency has or shall benefit financially or materially from this Contract. This Contract may be terminated by LDH if it is determined that gratuities of any kind were offered to, or received by, any officials or employees of the state, its agents, or employees.

6.42 Order of Precedence

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

6.42.1 The body of the Contract with exhibits and attachments, excluding the RFP and the Contractor's proposal;

6.42.2 The RFP and any addenda and appendices;

6.42.3 The **MCO Manual;** and

6.42.4 The Proposal submitted by the Contractor in response to the RFP.

6.43 Physician Incentive Plans

6.43.1 The Contractor shall comply with requirements for physician incentive plans, as required by 42 C.F.R. §438.3(i) and set forth in 42 C.F.R. §422.208 and §422.210.

6.43.2 Each organization will provide to LDH assurance which is satisfactory to the Secretary of HHS that the requirements of 42 C.F.R. §422.208 are met.

6.44 Political Activity

None of the funds, materials, property, or services provided directly or indirectly under this Contract shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the Hatch Act of 1939.

6.45 Prohibited Payments

Payment for the following shall not be made:

6.45.1 Organ transplants, unless the State Plan has written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to enrollees;

6.45.2 Non-emergency services provided by or under the direction of an excluded individual;

6.45.3 Any amount expended for which funds may be not used under the Assisted Suicide Funding Restriction Act of 1997;

6.45.4 Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State Plan; and

6.45.5 Any amount expended for home health care services unless the MCO ensures that the provider meets the appropriate surety bond requirements.

6.46 Rate Adjustments

The Contractor and LDH both agree that the monthly capitation rates identified in this Contract shall be in effect during the period identified on the MCO Rate Schedule that shall be posted on LDH's website. Rates may be adjusted during the Contract period based on LDH and actuarial analysis, subject to CMS review and approval.

The Contractor and LDH both agree that the adjustments to the monthly capitation rate(s) required pursuant to this Section shall occur only by written amendment to the Contract.

Should the Contractor refuse to accept a revised monthly capitation rate, it may request LDH in writing to permit the Contract to be terminated effective at least sixty (60) calendar days from the date of LDH's receipt of the written request. LDH shall have sole discretion to approve or deny the request for termination and to impose such conditions on the granting of an approval as it may deem appropriate, but it shall not unreasonably withhold its approval.

Should the Contractor refuse to accept the revised monthly capitation rate, at a minimum, the provisions of the Contract for contract turnover and performance bond shall apply.

6.47 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 the State and shall, upon request, be returned by the Contractor to the State, at the Contractor's expense, at termination or expiration of the Contract.

6.48 Record Retention for Awards to Recipients

6.48.1 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:

6.48.1.1 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;

6.48.1.2 Records for real property and equipment acquired with federal funds shall be retained for ten (10) years after final disposition;

6.48.1.3 When records are transferred to or maintained by LDH, the ten (10) year retention requirement is not applicable to the recipient; and

6.48.1.4 Indirect cost rate proposals, cost allocations plans, etc., as specified in 45 C.F.R. §75.361(f).

6.48.2 Under no circumstances shall the Contractor or any of its material subcontractors destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

6.49 References to Statutes, Rules, or Regulations

All references in this Contract to any statute, rule, or regulation shall be deemed to refer to the provisions of the statute, rule, or regulation as they exist at the time of the issuance of this Contract or as they may be hereafter amended. At any given time, the Contractor shall comply with the provisions that are currently in effect at that time.

6.50 Release of Records

The Contractor shall release medical records upon request by enrollees or their authorized representatives, as may be directed by authorized personnel of LDH, appropriate agencies of the State of Louisiana, or the United States Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in this Contract. The ownership and procedure for release of medical records shall be controlled by the Louisiana Revised Statutes of 1950, including but not limited to, La. R.S. 40:1165.1, La. R.S. 13:3734, and La. C. E. art. 510 and 45 C.F.R. Parts 160 and 164 (HIPAA Privacy Rule) and subject to reasonable charges. The Contractor shall not charge LDH or their designated agent for any copies of records requested.

6.51 Reporting Changes

The Contractor shall immediately notify LDH of any of the following:

6.51.1 Change in business address, telephone number, facsimile number, and e-mail address;

6.51.2 Change in corporate status or nature;

6.51.3 Change in business location;

6.51.4 Change in solvency;

6.51.5 Change in corporate officers, executive employees, or corporate structure;

6.51.6 Change in ownership, including but not limited to the new owner's legal name, business address, telephone number, facsimile number, and e-mail address;

6.51.7 Change in incorporation status;

6.51.8 Change in federal employee identification number or federal tax identification number; and/or

6.51.9 Change in Contractor litigation history, current litigation, audits and other government investigations both in Louisiana and in other states.

6.52 Right to Audit

The State Legislative Auditor, agency, and/or federal auditors and internal auditors of the Division of Administration shall have the option to audit all accounts directly pertaining to the Contract for a period of five (5) years from the date of the last payment made under this Contract. Records shall be made available during normal working hours for this purpose.

6.53 Safeguarding Information

The Contractor shall establish written safeguards that restrict the use and disclosure of information concerning enrollees or potential enrollees to purposes directly connected with the performance of this Contract. The Contractor's written safeguards shall:

6.53.1 Be comparable to those imposed upon the LDH by 42 C.F.R. Part 431, Subpart F, and La. R.S. 46:56;

6.53.2 State that the Contractor 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;

6.53.3 Require a written authorization from the enrollee or potential enrollee before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 C.F.R. §164.508;

6.53.4 Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

6.53.5 Specify appropriate personnel actions to sanction violators.

6.54 Safety Precautions

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

6.55 Severability

If any provision of this Contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void by a judgment or order of a court of competent jurisdiction, then both LDH and the MCO shall be relieved of all obligations arising under such provision. If the remainder of this Contract is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed. In addition, if the laws or regulations governing this Contract should be amended or judicially interpreted as to render the fulfillment of the Contract impossible or economically infeasible, both LDH and the Contractor will be discharged from further obligations created under the terms of the Contract.

6.56 Software Reporting Requirement

All reports submitted to LDH by the Contractor shall be in a format accessible and modifiable by the standard Microsoft Office Suite of products, Version 2007 or later, or in a format accepted and approved by LDH.

6.57 Termination for Convenience

LDH may terminate this Contract for convenience and without cause upon sixty (60) calendar days' written notice. LDH shall not be responsible to the MCO or any other party for any costs, expenses, or damages occasioned by said termination, i.e., this termination is without penalty.

6.58 Termination Due to Serious Threat to Health of Enrollees

LDH may terminate this Contract immediately if it is determined that actions by the Contractor or its subcontractor(s) pose a serious threat to the health of its enrollees.

6.59 Termination for MCO Insolvency, Bankruptcy, or Instability of Funds

6.59.1 The Contractor's insolvency or the filing of a petition in bankruptcy by or against the Contractor shall constitute grounds for termination for cause. If LDH determines the Contractor has become financially unstable, LDH shall immediately terminate this Contract upon written notice to the Contractor effective the close of business on the date specified.

6.59.2 The Contractor shall cover continuation of services to enrollees for the duration of any period for which payment has been made, as well as for inpatient admissions up until discharge.

6.60 Termination for Ownership Violations

The Contractor is subject to termination, unless the Contractor can demonstrate changes of ownership or control, when:

6.60.1 A person with a direct or indirect ownership interest in the Contractor:

6.60.1.1 Has been convicted of a criminal offense under 42 U.S.C. §1320a-7(a), (b)(1) or (3), in accordance with 42 C.F.R. §1002.203;

6.60.1.2 Has had civil liquidated damages or assessment imposed under 42 U.S.C. §1320a-7a; or

6.60.1.3 Has been excluded from participation in Medicare or any state health care program.

6.60.2 Any individual who is an affiliate or an officer (if the Contractor is organized as a corporation), or who is a partner (if it is organized as a partnership), or who is an agent or a managing employee, is under temporary management as defined in the *Contract Non-Compliance* section.

6.60.3 The Contractor has a direct or indirect substantial contractual relationship with an excluded individual or entity.

6.61 Termination for Unavailability of Funds

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

6.61.2 The Contractor has the duty to fully cooperate with the State and provide any and all requested information, documentation, etc. at its earliest convenience to the State when requested. This applies even if a contract is terminated and/or a lawsuit is filed. Specifically, the Contractor does not have the right to limit or impede the State's right to audit or to withhold State-owned documents.

6.62 Time is of the Essence

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

6.63 Titles

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

6.64 Use of Data

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

6.65 Waiver

The waiver by LDH of any breach of any provision contained in this Contract shall not be deemed to be a waiver of such provision on any subsequent breach of the same or any other provision contained in this Contract and shall not establish a course of performance between the parties contradictory to the terms hereof.

6.66 Warranty to Comply with State and Federal Regulations

The Contractor warrants that it shall comply with all state and federal laws and regulations as they exist at the time of the Contract or as subsequently amended.

6.67 Warranty of Removal of Conflict of Interest

The Contractor warrants that it, its officers, and its employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services hereunder. The Contractor shall periodically inquire of its officers and employees concerning such conflicts, and shall inform LDH promptly of any potential or actual conflict(s). The Contractor warrants that it shall remove any conflict of interest prior to signing the Contract and during the term of the Contract.

6.68 Withholding in Last Month of Payment

During the transition to a new Contractor, for the last month of the Contract, the Department shall withhold seventy-five percent (75%) of the final payment to the Contractor for a maximum of ninety (90) calendar days from the due date of such amount to ensure that the outgoing Contractor fulfills its contractual obligations and repays LDH for payments made on behalf of ineligible enrollees, some of which may extend past the term of the Contract.