Office of State Procurement
PROACT Contract Certification of Approval

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

Reference Number: 2000107180 (4)
Vendor: UnitedHealthcare of Louisiana Inc
Description: Provide healthcare services to Medicaid enrollees
Approved By: Pamela Rice
Approval Date: 1/05/2016

Your amendment that was submitted to OSP has been approved.

Rev 2010/08

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

Medical Vendor Administration

(Regional/ Program/ Facility)

AND

United Healthcare of LA, Inc. d/b/a United Healthcare Community Pl

Contractor Name

Amendment #: 4

LaGov #: 2000107180

CFMS #: 733524

DHH #: 060470

Original Contract Amt 1,964,731,789

Original Contract Begin Date 02-01-2015

Original Contract End Date 01-31-2018

AMENDMENT PROVISIONS

Change Contract From: Maximum Amount: 1,964,731,789

See Attachment A-4.

Change To: Maximum Amount: 3,332,812,700

See Attachment A-4.

Justification:

The changes contained in Attachment A-4 are necessary for the integration of specialized behavioral health services and the continued successful operation of the Medicaid managed care program.

This Amendment Becomes Effective: 12-01-2015

This amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this amendment is signed and entered into on the date indicated below.

CONTRACTOR

United Healthcare of LA, Inc. d/b/a United Healthcare Commu

CONTRACTOR SIGNATURE 12/1/2015 DATE

PRINT NAME: John H. Lovelady

CONTRACTOR TITLE: CEO

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Secretary, Department of Health and Hospital or Designee

SIGNATURE 12/8/15 DATE

NAME: J. Ruth Kennedy

TITLE: Medicaid Director

OFFICE: Bureau of Health Services Financing

PROGRAM SIGNATURE DATE

NAME

Attachment/ Exhibit Letter or Number	Contract Document Name	Change From:	Change To[1]:	Justification
Attachment D	Rate Certification		Replace with Mercer rate certification dated October 15, 2015.	A rate revision was necessary to address technical changes related to out-of-state hospital payments and kick payments, as well as programmatic changes related to the termination of LaHIPP and the addition of new mandatory populations.
Attachment I	Behavioral Health Rate Certification	New attachment	Add Mercer rate certification dated November 20, 2015.	Specialized behavioral health services are being integrated into Bayou Health and rates for these services were developed by Mercer
Attachment J	Non-Emergency Medical Transportation Rate Certification	New attachment	Add Mercer Rate certification dated November 4, 2015.	All non-emergency transportation services will be provided by the MCOs and rates for these services were developed Mercer.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA		Changes are contained in the redlined version of the RFP.	Specialized behavioral health services are being integrated into Bayou Health.

[1] Additions underlined; deletions struck through

Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA **Appendix O**		Replaced with updated version.-	Changes were made to add requirements related to the assignment of anti-trust rights to the State of Louisiana.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA **Appendix T –** Request for Member Disenrollment		Replaced with updated version.	Changes were made due to the integration of specialized behavioral health services into Bayou Health.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA **Appendix UU** – Behavioral Health Provider Network – Geographic and Capacity Standards		Replaced with updated version.	Changes were made due to the integration of specialized behavioral health services into Bayou Health.

Jaredd Simons, ASA, MAAA
Senior Associate Actuary

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Ms. Jen Steele
Medicaid Deputy Director
Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70821

October 15, 2015

Subject: Louisiana Bayou Health Physical Health Services – Full Risk-Bearing Managed Care Organization Rate Range Development and Actuarial Certification update for the Period December 1, 2015 through January 31, 2016

Dear Ms. Steele:

The Louisiana Department of Health and Hospitals (DHH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for the State of Louisiana's Bayou Health program for the period of December 1, 2015 through January 31, 2016. This certification update includes two technical revisions that are retrospectively effective February 1, 2015 and two programmatic changes that will be effective December 1, 2015. For reference, the original capitation rate certification letter for the period July 1, 2015 through January 31, 2016 is included with this document in Appendix E.

This letter provides an overview of the analyses and methodology to support the technical revisions, programmatic changes, and the resulting capitation rate ranges effective December 1, 2015 through January 31, 2016 for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS). This rate development process used Medicaid fee-for-service (FFS) medical and pharmacy claims, Bayou Health Shared Savings claims experience, and Bayou Health Prepaid encounter data. It resulted in the development of a range of actuarially sound rates for each rate cell. The capitation rate ranges are summarized in Appendix A and represent payment in full for the covered services. Appendix B shows the full rate development from the base data as shown in the data book released by the State, dated January 31, 2015 (after excluding LaHIPP claims and including the revised Maternity kick payment deliveries {Table 1-A and 1-B}), and applies all the rate setting adjustments as described in this letter.

Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows,

governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate, and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government mandated assessments, fees, and taxes, and the cost of capital. Note: Please see pages 8-9 of the August 2005, Actuarial Certification of Rates for Medicaid Managed Care Programs, from the American Academy of Actuaries, http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.

Technical Revisions

Following the implementation of the Bayou Health at-risk capitated program, effective February 1, 2015, Mercer became aware of two issues requiring a technical revision to the previously certified rates. These are the following:

- A misalignment in the Maternity kick payment delivery event count logic between the State's fiscal agent and what was included in rate development.
- A decision made by the First Circuit Court of Appeals altering the reimbursement to out-of-state border hospitals.

These issues and methodology of the technical revisions are described in detail in the following sections.

Technical Revision #1 (Maternity Kick Payment Delivery Event Count Logic)

Mercer worked with DHH and the State's fiscal agent (Molina) to revise and align the Maternity kick payment delivery event count logic underlying the rate development and the logic implemented by Molina for payment to the Bayou Health managed care organizations (MCOs). A full description of the Maternity kick payment logic can be found in Schedule Z of the Bayou Health MCO financial reporting requirements guideline.

The following describes all the changes made to the inpatient physical health services encounters delivery event count logic. All other logic remains unchanged:

- Included all available diagnoses codes on a claim to identify a delivery. Previously, only the primary diagnosis code was used to identify a delivery.
- Included inpatient hospital claims only (claim type = 01 and billing provider type = 60) to identify a delivery. Previously, outpatient claims and all billing provider types were considered to identify a delivery.
- Restricted the age of the enrolled mother to greater than or equal to 10 years of age to identify a delivery. Previously, all ages were considered to identify a delivery.

- Diagnoses code range 640-669 where the 5th digit must be a 1 or 2. Previously, all codes in the range 650-669 were used to identify a delivery and no consideration was made for the 5th digit.
- Stillborn deliveries are identified using the following revenue codes: V271, V273-274, or V276-277. Previously, all V27 (V271-V279) were used to identify a stillborn delivery.

The following describes all the changes made to the professional encounters delivery logic, all other logic remains unchanged:

- Restricted to billing provider types 19, 20, and 90 to identify a delivery. Previously, all billing provider types were considered to identify a delivery.
- Restricted the age of the recipient to greater than or equal to 10 years of age to identify a delivery. Previously, all ages were considered to identify a delivery.

Additionally, after all encounters are identified, a single live-born delivery is identified for a given recipient within a 245-day period, plus or minus. Previously, a 120-day period, plus or minus, was used to identify a single delivery.

The revision to the Maternity kick payment delivery event count logic resulted in a reduction in deliveries of 1.98%, which increased the cost per delivery by 2.02%. Table 1-A shows the regional impact to the Maternity kick payment deliveries and cost per delivery. Table 1-B shows the regional impact to the Full Medicaid Pricing (FMP) cost per delivery.

Table 1-A: Regional impact to deliveries and cost per delivery due to the Maternity kick payment delivery event count logic change

Region Description	CY 2013 Deliveries	Original Cost per Delivery	CY 2013 Revised Deliveries	Revised Cost per Delivery	Deliveries % Change	Cost per Delivery % Change	Cost Per Delivery Impact
Gulf	10,987	$5,758.51	10,706	$5,910.05	-2.56%	2.63%	$151.54
Capital	9,772	$5,100.71	9,480	$5,258.10	-2.99%	3.09%	$157.40
South Central	10,504	$5,063.13	10,352	$5,137.39	-1.45%	1.47%	$74.27
North	8,132	$5,207.82	8,080	$5,241.63	-0.65%	0.65%	$33.82
Statewide	**39,396**	**$5,296.26**	**38,617**	**$5,403.03**	**-1.98%**	**2.02%**	**$106.78**

Table 1-B: Regional impact to FMP cost per delivery due to delivery event count logic change

Region Description	CY 2013 Deliveries	Original FMP Cost per Delivery	Revised Deliveries	Revised FMP Cost per Delivery	FMP Cost per Delivery % Change	FMP Cost Per Delivery Impact
Gulf	10,987	$3,053.19	10,706	$3,133.54	2.63%	$80.35
Capital	9,772	$3,046.41	9,480	$3,140.42	3.09%	$94.01
South Central	10,504	$2,662.95	10,352	$2,702.01	1.47%	$39.06
North	8,132	$2,632.96	8,080	$2,650.06	0.65%	$17.10
Statewide	**39,396**	**$2,860.71**	**38,617**	**$2,918.39**	**2.02%**	**$57.68**

Technical Revision #2 (Out-of-State Border Hospital Reimbursement)

A First Circuit Court of Appeals decision, Vicksburg, LLC v. State ex rel. Dep't of Health and Hospitals, 2010-1248 (La. App. 1st Cir. 3/25/11), 63 So.3d205, determined that a reimbursement methodology promulgated by DHH was unconstitutional in its application to River Region. River Region is a hospital located in Vicksburg, Mississippi, and administered inpatient health care services to Louisiana Medicaid patients. Consequently, DHH altered its reimbursement methodology to Mississippi out-of-state (Mississippi trade area) border hospitals from a per diem basis to a percentage of billed charges. These hospitals will now be reimbursed at 60% and 40% of billed charges for children and adults, respectively.

Mercer re-priced these out-of-state border hospital claims using the base claims experience (calendar year {CY} 2013) and determined the change to be immaterial to all rating categories with the exception of the Maternity kick payment. The South Central and North regions' Maternity kick payments were affected most with a 4.78% and 1.60% increase, respectively, as these are the regions bordering the Mississippi trade area. There was minimal to no impact to the Maternity kick payments of the Capital and Gulf regions. Table 2 shows the regional impact to the Maternity kick payments cost per delivery.

Table 2: Regional impact to cost per delivery due to the out-of-state border hospitals reimbursement methodology change

Region Description	CY 2013 Revised Deliveries	Table 1-A Revised Cost per Delivery	Out of State Inpatient Hospital Adjustment	Revised Cost per Delivery	Cost Per Delivery Impact
Gulf	10,706	$5,910.05	0.00%	$5,909.95	($0.10)
Capital	9,480	$5,258.10	0.04%	$5,260.37	$2.27
South Central	10,352	$5,137.39	4.78%	$5,382.83	$245.44
North	8,080	$5,241.63	1.60%	$5,325.55	$83.91
Statewide	**38,617**	**$5,403.03**	**1.55%**	**$5,486.91**	**$83.88**

Table 3: Total impact of the technical revisions

		Delivery Count Logic Update Impact		OOS IP Hospital Adj. Impact	
	[A]	[B]	[C]	[D]	[E]= [A]+[B]+[C]+[D]
Region Description	Original Total Cost per Delivery[1]	Cost Per Delivery Impact[2]	FMP Cost per Delivery Impact[3]	Cost Per Delivery Impact[4]	Revised Total Cost Per Delivery
Gulf	$8,811.70	$151.54	$80.35	($0.10)	$9,043.49
Capital	$8,147.12	$157.40	$94.01	$2.27	$8,400.79
South Central	$7,726.08	$74.27	$39.06	$245.44	$8,084.84
North	$7,840.78	$33.82	$17.10	$83.91	$7,975.61

Notes:
1: Target cost per delivery certified in the August 11, 2015 letter for the period July 1, 2015 through January 31, 2016.
2: Limited cost per delivery impact shown in Table 1-A.
3: FMP cost per delivery impact shown in Table 1-B.
4: Limited cost per delivery impact shown in Table 2.

Programmatic Changes

Effective December 1, 2015, DHH will implement two program changes to Bayou Health:

- The termination of the Louisiana's Health Insurance Premium Payment (LaHIPP) program.
- The mandatory enrollment of populations who were previously allowed to voluntarily opt-out of Bayou Health.

The details of the methodology used to quantify and reflect the impact of the aforementioned program changes are described in the following sections.

Programmatic Change #1 (LaHIPP Program)
Effective December 1, 2015, DHH will terminate the LaHIPP program. This program pays for some or all of the health insurance premiums for an enrollee if they have insurance available through someone in the family and are enrolled in Medicaid. The program also covers out of pocket expenses incurred by the enrollee (Medicaid is the secondary payer).

LaHIPP is not a category of eligibility and enrollees in this program were eligible under the other categories of aid (COA) in Bayou Health. LaHIPP membership and claims experience were removed from the base claims experience (CY 2013) for purposes of developing the capitation rate range. Appendix C shows the statewide impact by COA from removing LaHIPP enrollees from the base claims experience. The LaHIPP claims are explicitly provided in the data book dated January 31, 2015.

Programmatic Change #2 (Voluntary Opt-Out Populations)
Effective December 1, 2015, populations currently allowed to voluntarily opt-out of Bayou Health will become mandatorily enrolled. These populations are defined in section 3.1 of the contract as the following:

- Children under 19 years of age who are:
  - Eligible for Supplemental Security Income (SSI) under title XVI of the Social Security Act;
  - Eligible under Section 1902(e)(3) of the Social Security Act;
  - In foster care or other out-of-home placement;
  - Receiving foster care or adoption assistance;
  - Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of title V of the Social Security Act, and is defined by the DHH in terms of either program participation or special health care needs; or
  - Enrolled in Family Opportunity Act Medicaid Buy-In Program
- Native Americans who are members of federally recognized tribes, except when the MCO is:
  - The Indian Health Service; or
  - An Indian health program or urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreements or compact with the Indian Health Service.

Mercer used logic provided by DHH to identify SSI and foster care children who have opted-out of Bayou Health; however, there was no clearly defined logic available to Mercer to identify Native Americans. Thus, for base claims experience, Mercer utilized the residual CY 2013 FFS claims incurred by FFS populations who met the criteria for inclusion into Bayou Health and were not identified as a voluntary opt-in population (home- and community-based services {HCBS} Waiver and Chisholm Class Members), as defined in section 3.2 of the contract.

After identifying the appropriate voluntary opt-out populations' CY 2013 FFS membership and claims experience, Mercer created an adjustment to be applied in the rate development to account for the voluntary opt-out experience. When reviewing the opt-out experience to create this adjustment, Mercer accounted for the same rating adjustments as the Shared Savings/FFS population in the capitation rates effective February 1, 2015. These adjustments include:

- Incurred but not reported (IBNR)
- Fee adjustments
- Retroactive eligibility
- Fraud and abuse recoupments
- ACT 312 and pharmacy rebates
- Pediatric Day Health Care adjustments
- Specialized behavioral health mixed services protocol
- Affordable Care Act (ACA) Primary Care Providers (PCP) enhanced payments
- Trend

As the opt-out population has not been previously covered by the Bayou Health program, additional considerations had to be taken for the trend duration for the opt-out experience. The population covered under Bayou Health effective February 1, 2015 has a trending midpoint of August 1, 2015. The rating period for the voluntary opt-out population is December 1, 2015 through January 31, 2015 and therefore has a trending midpoint of January 1, 2015. Mercer accounted for the five month difference in trending midpoint for the opt-out population.

Additionally, Mercer used specific managed care contracting adjustments for the voluntary opt-out population. Considering the short rating period for the voluntary opt-outs, Mercer did not apply contracting adjustments for utilization but did apply a 1.0% to 3.0% increase for unit cost.

The overall adjustment for the inclusion of the voluntary opt-out populations can be found in Appendix D.

Certification of Rate Ranges

In preparing the rate ranges shown in Appendix A, Mercer has used and relied upon enrollment, FFS claims, encounter data, reimbursement level, benefit design, and other information supplied by DHH and its fiscal agent. DHH, its fiscal agent, and the Prepaid plans are responsible for the validity and completeness of the data supplied. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion they are appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies that the rates in Appendix A were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the managed care contract. Rate estimates provided are based upon the information available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rates and ranges developed by Mercer are actuarial projections of future contingent events. Actual Bayou Health MCO costs will differ from these projections. Mercer has developed these rates on behalf of DHH to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c), and in accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

Bayou Health MCOs are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges by Bayou Health MCOs for any purpose. Mercer recommends that any Bayou Health MCO considering contracting with DHH should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rate ranges before deciding whether to contract with DHH.

This certification letter assumes the reader is familiar with the Bayou Health program, Medicaid eligibility rules, and actuarial rate-setting techniques. It is intended for DHH and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

If you have any questions on any of the information provided, please feel free to call me at +1 404 442 3358.

Sincerely,



Jaredd Simons, ASA, MAAA
Senior Associate Actuary

Appendix A: Bayou Health Physical Health Services Capitation Rate Range

Region Description	COA Description	Rate Cell Description	CY 2013 MMs or Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
Gulf	SSI	0-2 Months	287	$27,550.49	$28,980.93
Gulf	SSI	3-11 Months	1,728	$5,306.40	$5,598.82
Gulf	SSI	Child 1-18	121,839	$415.04	$442.48
Gulf	SSI	Adult 19+	276,046	$1,017.76	$1,071.30
Gulf	Family & Children	0-2 Months	43,082	$1,762.38	$1,854.57
Gulf	Family & Children	3-11 Months	104,284	$247.57	$264.13
Gulf	Family & Children	Child 1-18	2,050,898	$120.22	$128.10
Gulf	Family & Children	Adult 19+	373,887	$324.28	$342.34
Gulf	BCC	BCC, All Ages	3,695	$2,303.99	$2,450.13
Gulf	LAP	LAP, All Ages	9,457	$154.82	$165.54
Gulf	HCBS	Child 0-18	6,538	$1,550.29	$1,682.92
Gulf	HCBS	Adult 19+	20,790	$615.74	$662.30
Gulf	CCM	CCM, All Ages	15,581	$902.87	$983.44
Gulf	Maternity Kick Payment	Maternity Kick Payment	10,700	$9,017.48	$9,270.19
Gulf	EED Kick Payment	EED Kick Payment	N/A	$5,154.77	$5,241.55
Capital	SSI	0-2 Months	163	$28,413.29	$29,843.73
Capital	SSI	3-11 Months	1,461	$5,394.45	$5,686.88
Capital	SSI	Child 1-18	88,633	$450.26	$482.06
Capital	SSI	Adult 19+	209,421	$1,046.13	$1,107.31
Capital	Family & Children	0-2 Months	38,631	$1,911.98	$2,007.10
Capital	Family & Children	3-11 Months	94,165	$266.72	$285.60
Capital	Family & Children	Child 1-18	1,858,073	$127.17	$135.85
Capital	Family & Children	Adult 19+	268,605	$370.09	$391.17
Capital	BCC	BCC, All Ages	3,946	$2,296.45	$2,442.59
Capital	LAP	LAP, All Ages	10,487	$156.09	$166.80
Capital	HCBS	Child 0-18	6,774	$1,549.11	$1,681.75

Region Description	COA Description	Rate Cell Description	CY 2013 MMs or Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
Capital	HCBS	Adult 19+	20,494	$615.61	$662.17
Capital	CCM	CCM, All Ages	15,381	$903.89	$984.46
Capital	Maternity Kick Payment	Maternity Kick Payment	9,457	$8,357.75	$8,581.28
Capital	EED Kick Payment	EED Kick Payment	N/A	$5,401.33	$5,498.12
South Central	SSI	0-2 Months	213	$27,684.14	$29,114.58
South Central	SSI	3-11 Months	1,662	$5,304.60	$5,597.03
South Central	SSI	Child 1-18	90,974	$484.83	$516.46
South Central	SSI	Adult 19+	246,315	$967.55	$1,021.90
South Central	Family & Children	0-2 Months	43,407	$2,105.59	$2,205.16
South Central	Family & Children	3-11 Months	104,247	$284.68	$302.96
South Central	Family & Children	Child 1-18	2,034,374	$135.19	$144.12
South Central	Family & Children	Adult 19+	285,291	$341.45	$360.97
South Central	BCC	BCC, All Ages	2,890	$2,311.73	$2,457.87
South Central	LAP	LAP, All Ages	12,222	$156.88	$167.60
South Central	HCBS	Child 0-18	6,213	$1,552.76	$1,685.39
South Central	HCBS	Adult 19+	22,305	$617.28	$663.84
South Central	CCM	CCM, All Ages	16,290	$903.12	$983.69
South Central	Maternity Kick Payment	Maternity Kick Payment	10,347	$8,073.21	$8,303.76
South Central	EED Kick Payment	EED Kick Payment	N/A	$4,915.62	$5,010.65
North	SSI	0-2 Months	239	$27,956.38	$29,386.81
North	SSI	3-11 Months	1,678	$5,304.79	$5,597.21
North	SSI	Child 1-18	99,769	$446.00	$473.76
North	SSI	Adult 19+	211,578	$923.45	$974.40
North	Family & Children	0-2 Months	32,218	$1,994.51	$2,095.51
North	Family & Children	3-11 Months	80,049	$262.11	$279.64
North	Family & Children	Child 1-18	1,586,038	$121.51	$129.34
North	Family & Children	Adult 19+	213,578	$326.14	$344.95
North	BCC	BCC, All Ages	2,395	$2,326.15	$2,472.29

Region Description	COA Description	Rate Cell Description	CY 2013 MMs or Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
North	LAP	LAP, All Ages	6,545	$156.89	$167.60
North	HCBS	Child 0-18	3,944	$1,553.38	$1,686.01
North	HCBS	Adult 19+	16,992	$617.35	$663.91
North	CCM	CCM, All Ages	16,296	$903.59	$984.16
North	Maternity Kick Payment	Maternity Kick Payment	8,077	$7,945.67	$8,173.23
North	EED Kick Payment	EED Kick Payment	N/A	$4,660.27	$4,746.63

Appendix B: Development of Rate Ranges for December 1, 2015 through January 31, 2016

Rate Development Description

The below portrays the details of the rate development based on the combined Prepaid, Shared Savings, and Legacy Medicaid/FFS (Chisholm and HCBS) data. The rate development exhibit takes the base data that was provided in Attachment 1 of the data book issued on January 31, 2015, (after excluding LaHIPP claims and including the revised Maternity kick payment deliveries {Table 1-A}), and applies the various rate-setting adjustments. The columns in the exhibit are as follows:

Base Data – The base data in these columns includes IBNR.
Member Month (MMs) – MMs for the CY 2013 period.
Per Member Per Month (PMPM) – Computed as the total paid amount divided by the total MMs. Statewide PMPMs were used where appropriate, as indicated in the rate certification letter.

Base Data Adjustments:
Annual Trend – (Low & High) – Annualized trend that is equivalent to the trend factor applied to the base data.
Trend Factor – (Low & High) – Trend factor that is equivalent to the compounded annualized trend applied to the base data.
Base Period Adj. – Overall base period adjustment applied to both the low and high PMPMs. A list of the data source-specific adjustments and the level of detail in which they were applied can be found in the table below:

Base Period Adjustments	
Prepaid	**Shared/FFS**
	Fraud and Abuse Adjustment (statewide adj.)
Fee Schedule Adjustment (hospital specific adj.)	Fee Schedule Adjustment (hospital specific adj.)
ACT 312 Adjustment (statewide adj.)	ACT 312 Adjustment (statewide adj.)
	Rx Rebate Adjustment (statewide adj.)
ACA PCP Adjustment (category of service level adj.)	ACA PCP Adjustment (category of service level adj.)
LBHP Adjustment (category of service level adj.)	LBHP Adjustment (category of service level adj.)
Retro-activity Adjustment (rate cell level adj.)	Retro-activity Adjustment (rate cell level adj.)
NEMT Adjustment (rate cell level adj.)	

Managed Care Adj. Factor – (Low & High) – Low and high managed care savings factors applied to the corresponding low and high PMPMs. A list of the data source-specific adjustments and the level of detail in which they were applied can be found in the table below:

Managed Care Adjustments

Prepaid	Shared/FFS
Managed Care Savings*	Managed Care Savings*
	GDR

* Managed care savings adjustments were applied to previously unmanaged populations utilizing Legacy Medicaid/FFS claims (HCBS and Chisholm), as well as newly added services.

Voluntary Opt-Out Adj. Factor – (Low & High) – Low and high factors applied to the corresponding low and high PMPMs for mandating the voluntary opt-out populations.
Out-of-State Adj. Factor – Factor applied to account for the out-of-state border hospitals reimbursement change. Applies to both Low and High PMPMs.
Outlier Add-on (PMPM) – PMPM added to account for outlier payments. Applies to both Low and High PMPMs.
Claims PMPM – (Low) – Calculated as: N = [B *E * (1+G)*H*J*L] + M.
Claims PMPM – (High) – Calculated as: O = [B * F * (1+G)*I*K*L] + M.
Fixed Admin Load – (Low & High) – A PMPM adjustment added to the corresponding Low and High PMPMs.
Variable Admin Load – (Low & High) – A percentage adjustment applied to the corresponding Low and High PMPMs.
Profit @ 2% – Provision in these rates has been made for a 2% risk margin.
Premium Tax @ 2.25% – Provision in these rates has been made for Louisiana's 2.25% premium tax.
PMPM After Admin – (Low) – Calculated as: V = (N * (1 + Q) + P)/(1 – T – U).
PMPM After Admin – (High) – Calculated as: W = (O * (1 + S) + R)/(1 – T – U).
Full Medicaid Pricing (FMP) Add-On – FMP component of the rate.
Premium tax on FMP – Provision in the FMP component of the rates has been made for Louisiana's 2.25% premium tax.
Final Loaded Rates – (Low) – Calculated as: Z = V + X + Y.
Final Loaded Rates – (High) – Calculated as: AA = W + X + Y.

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October 15, 2015
Ms. Jen Steele
Louisiana Department of Health and Hospitals

			Base Data		Base Data Adjustments										Outliers			Capitation Rate Load								Full Medicaid Payment			
			A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA
Region Name	COA Desc	Rate Cell Code	MMs	PMPM	Annual Trend-Low	Annual Trend-High	Trend Factor-Low	Trend Factor-High	Base Period Adj.	Managed Care Adj. Factor-Low	Managed Care Adj. Factor-High	Voluntary Opt-Out Adj. Factor - Low	Voluntary Opt-Out Adj. Factor - High	Out of State Hospital Adj. Factor	Outlier Add-on - PMPM	Claims PMPM-Low	Claims PMPM-High	Fixed Admin Load- Low (PMPM)	Variable Admin Load- Low (%)	Fixed Admin Load- High (PMPM)	Variable Admin Load- High (%)	Profit @ 2%	Premium Tax @ 2.25%	PMPM After Admin- Low	PMPM After Admin- High	FMP Add-On	Premium tax on FMP	Final Loaded Rates-Low	Final Loaded Rates-High
Gulf	SSI	Newborn, 0-2 Months	267	$ 19,659.26	0.4%	3.8%	1.01	1.06	-5.0%	1.00	1.00	0.91	0.92	1.00	$ 945.10	$ 18,120.97	$ 19,413.84	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 20,075.10	$ 21,505.54	$ 7,307.19	$ 168.20	$ 27,550.49	$ 28,980.93
Gulf	SSI	Newborn, 3-11 Months	1,728	$ 4,031.32	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	0.97	0.97	1.00	$ 63.79	$ 3,991.93	$ 4,256.71	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,410.05	$ 4,702.48	$ 876.18	$ 20.17	$ 5,306.40	$ 5,598.82
Gulf	SSI	Child, 1-18 Years	121,839	$ 293.29	2.9%	5.9%	1.06	1.13	-1.4%	0.98	0.99	1.09	1.09	1.00	$ 2.39	$ 330.23	$ 354.60	$ 10.89	4.4%	$ 11.67	4.4%	2.0%	2.25%	$ 371.52	$ 396.97	$ 42.54	$ 0.98	$ 415.04	$ 440.48
Gulf	SSI	Adult, 19+ Years	276,046	$ 682.56	2.9%	5.9%	1.06	1.13	0.4%	0.99	0.99	1.00	1.00	1.00	$ -	$ 717.96	$ 766.17	$ 10.89	4.3%	$ 11.67	4.4%	2.0%	2.25%	$ 793.72	$ 847.25	$ 219.00	$ 5.04	$ 1,017.76	$ 1,071.30
Gulf	Family and Children	Newborn, 0-2 Months	43,082	$ 1,151.97	0.7%	4.1%	1.01	1.09	-7.5%	1.00	1.00	1.03	1.04	1.00	$ 46.33	$ 1,160.18	$ 1,242.84	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,295.55	$ 1,387.74	$ 456.32	$ 10.50	$ 1,762.38	$ 1,854.57
Gulf	Family and Children	Newborn, 3-11 Months	104,284	$ 200.83	2.3%	5.8%	1.05	1.12	-10.6%	0.97	0.97	1.00	1.00	1.00	$ 0.21	$ 182.41	$ 196.72	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 212.01	$ 228.57	$ 34.76	$ 0.80	$ 247.57	$ 264.13
Gulf	Family and Children	Child, 1-18 Years	2,050,898	$ 89.55	3.0%	6.2%	1.06	1.13	-4.9%	0.95	0.96	1.00	1.00	1.00	$ 0.05	$ 86.25	$ 92.69	$ 10.89	4.7%	$ 11.67	4.8%	2.0%	2.25%	$ 105.73	$ 113.60	$ 14.17	$ 0.33	$ 120.22	$ 128.10
Gulf	Family and Children	Adult, 19+ Years	373,887	$ 214.99	2.9%	5.9%	1.06	1.13	1.7%	0.96	0.97	1.01	1.01	1.00	$ -	$ 225.50	$ 241.23	$ 10.89	4.8%	$ 11.67	4.8%	2.0%	2.25%	$ 258.19	$ 276.25	$ 64.60	$ 1.49	$ 324.28	$ 342.34
Gulf	Breast and Cervical Cancer	BCC, All Ages Female	3,695	$ 1,292.45	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	1.08	1.08	1.00	$ -	$ 1,572.30	$ 1,704.28	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,737.63	$ 1,883.77	$ 553.62	$ 12.74	$ 2,303.99	$ 2,450.13
Gulf	LaCHIP Affordable Plan	All Ages	9,457	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	1.00	1.00	1.00	$ -	$ 115.68	$ 124.73	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.73	$ 148.44	$ 16.71	$ 0.38	$ 154.82	$ 165.54
Gulf	HCBS Waiver	18 & Under, Male and Female	6,538	$ 1,368.00	2.0%	4.6%	1.04	1.10	0.5%	0.94	0.97	1.00	1.00	1.00	$ -	$ 1,349.97	$ 1,469.57	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,495.85	$ 1,628.48	$ 53.22	$ 1.23	$ 1,550.29	$ 1,682.92
Gulf	HCBS Waiver	19+ Years, Male and Female	20,790	$ 521.48	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	1.00	1.00	1.00	$ -	$ 480.29	$ 522.01	$ 10.89	4.3%	$ 11.67	4.3%	2.0%	2.25%	$ 534.32	$ 580.88	$ 79.59	$ 1.83	$ 615.74	$ 662.30
Gulf	Chisholm Class Members	Chisholm, All Ages Male & Female	15,581	$ 772.12	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	1.00	1.00	1.00	$ -	$ 749.15	$ 821.56	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 833.39	$ 913.96	$ 67.92	$ 1.56	$ 902.87	$ 983.44
Gulf	Maternity Kickpayment	Maternity Kickpayment, All Ages	10,700	$ 5,258.68	0.0%	2.0%	1.00	1.04	-0.6%	1.00	1.00	1.02	1.02	1.00	$ -	$ 5,311.39	$ 5,540.04	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 5,882.82	$ 6,135.53	$ 3,064.13	$ 70.53	$ 9,017.48	$ 9,270.19
Capital	SSI	Newborn, 0-2 Months	163	$ 19,659.26	0.4%	3.8%	1.01	1.06	-5.0%	1.00	1.00	0.91	0.92	1.00	$ 945.10	$ 18,120.97	$ 19,413.84	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 20,075.10	$ 21,505.54	$ 8,150.58	$ 187.61	$ 28,413.29	$ 29,843.73
Capital	SSI	Newborn, 3-11 Months	1,461	$ 4,031.32	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	0.97	0.97	1.00	$ 63.79	$ 3,991.93	$ 4,256.71	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,410.05	$ 4,702.48	$ 962.25	$ 22.15	$ 5,394.45	$ 5,686.88
Capital	SSI	Child, 1-18 Years	88,633	$ 344.62	3.0%	5.9%	1.06	1.13	1.4%	0.98	0.99	1.05	1.06	1.00	$ 2.39	$ 384.74	$ 413.11	$ 10.89	4.4%	$ 11.67	4.4%	2.0%	2.25%	$ 430.98	$ 462.78	$ 18.84	$ 0.43	$ 450.26	$ 482.06
Capital	SSI	Adult, 19+ Years	209,421	$ 748.67	3.0%	5.9%	1.06	1.13	4.1%	0.99	0.99	1.00	1.00	1.00	$ -	$ 817.86	$ 873.07	$ 10.89	4.3%	$ 11.67	4.4%	2.0%	2.25%	$ 902.61	$ 963.79	$ 140.29	$ 3.23	$ 1,046.13	$ 1,107.31
Capital	Family and Children	Newborn, 0-2 Months	38,631	$ 1,162.14	0.8%	4.0%	1.01	1.09	-6.4%	1.00	1.00	1.04	1.04	1.00	$ 46.33	$ 1,185.54	$ 1,270.85	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,323.48	$ 1,416.60	$ 575.26	$ 13.24	$ 1,911.98	$ 2,007.10
Capital	Family and Children	Newborn, 3-11 Months	94,165	$ 224.82	2.1%	5.6%	1.05	1.12	-7.5%	0.97	0.97	0.99	0.99	1.00	$ 0.21	$ 208.83	$ 225.26	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 241.12	$ 260.00	$ 25.03	$ 0.58	$ 266.72	$ 285.60
Capital	Family and Children	Child, 1-18 Years	1,858,073	$ 96.23	3.2%	6.3%	1.07	1.14	-1.8%	0.94	0.95	1.00	1.00	1.00	$ 0.05	$ 95.19	$ 102.39	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 115.37	$ 124.05	$ 11.54	$ 0.27	$ 127.17	$ 135.85
Capital	Family and Children	Adult, 19+ Years	268,605	$ 249.04	3.0%	5.9%	1.06	1.13	6.0%	0.96	0.97	1.00	1.00	1.00	$ -	$ 269.34	$ 287.85	$ 10.89	4.7%	$ 11.67	4.7%	2.0%	2.25%	$ 306.00	$ 327.08	$ 62.65	$ 1.44	$ 370.09	$ 391.17
Capital	Breast and Cervical Cancer	BCC, All Ages Female	3,946	$ 1,292.45	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	1.08	1.08	1.00	$ -	$ 1,572.30	$ 1,704.28	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,737.63	$ 1,883.77	$ 546.25	$ 12.57	$ 2,296.45	$ 2,442.59
Capital	LaCHIP Affordable Plan	All Ages	10,487	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	1.00	1.00	1.00	$ -	$ 115.68	$ 124.73	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.73	$ 148.44	$ 17.95	$ 0.41	$ 156.09	$ 166.80
Capital	HCBS Waiver	18 & Under, Male and Female	6,774	$ 1,368.00	2.0%	4.6%	1.04	1.10	0.5%	0.94	0.97	1.00	1.00	1.00	$ -	$ 1,349.97	$ 1,469.57	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,495.85	$ 1,628.48	$ 52.07	$ 1.20	$ 1,549.11	$ 1,681.75
Capital	HCBS Waiver	19+ Years, Male and Female	20,494	$ 521.48	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	1.00	1.00	1.00	$ -	$ 480.29	$ 522.01	$ 10.89	4.3%	$ 11.67	4.3%	2.0%	2.25%	$ 534.32	$ 580.88	$ 79.45	$ 1.83	$ 615.61	$ 662.17
Capital	Chisholm Class Members	Chisholm, All Ages Male & Female	15,381	$ 772.12	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	1.00	1.00	1.00	$ -	$ 749.15	$ 821.56	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 833.39	$ 913.96	$ 66.92	$ 1.59	$ 903.89	$ 984.46
Capital	Maternity Kickpayment	Maternity Kickpayment, All Ages	9,457	$ 4,642.97	0.0%	2.0%	1.00	1.04	0.3%	1.00	1.00	1.01	1.01	1.00	$ -	$ 4,707.64	$ 4,909.89	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 5,214.12	$ 5,437.65	$ 3,072.90	$ 70.73	$ 8,357.75	$ 8,581.28
South Central	SSI	Newborn, 0-2 Months	213	$ 19,659.26	0.4%	3.8%	1.01	1.06	-5.0%	1.00	1.00	0.91	0.92	1.00	$ 945.10	$ 18,120.97	$ 19,413.84	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 20,075.10	$ 21,505.54	$ 7,437.83	$ 171.20	$ 27,684.14	$ 29,114.58
South Central	SSI	Newborn, 3-11 Months	1,662	$ 4,031.32	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	0.97	0.97	1.00	$ 63.79	$ 3,991.93	$ 4,256.71	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,410.05	$ 4,702.48	$ 874.42	$ 20.13	$ 5,304.60	$ 5,597.03
South Central	SSI	Child, 1-18 Years	90,974	$ 344.26	3.4%	6.2%	1.07	1.13	0.4%	0.98	0.99	1.09	1.10	1.00	$ 2.39	$ 399.39	$ 427.67	$ 10.89	4.1%	$ 11.67	4.1%	2.0%	2.25%	$ 445.38	$ 477.02	$ 38.56	$ 0.89	$ 484.83	$ 516.46
South Central	SSI	Adult, 19+ Years	246,315	$ 682.00	3.0%	5.9%	1.06	1.13	1.0%	0.99	0.99	1.01	1.01	1.00	$ -	$ 726.58	$ 775.52	$ 10.89	4.4%	$ 11.67	4.4%	2.0%	2.25%	$ 803.41	$ 857.75	$ 160.45	$ 3.69	$ 967.55	$ 1,021.90
South Central	Family and Children	Newborn, 0-2 Months	43,407	$ 1,252.76	0.7%	4.1%	1.01	1.09	-6.8%	1.00	1.00	1.03	1.03	1.00	$ 46.33	$ 1,257.07	$ 1,346.41	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,402.85	$ 1,502.22	$ 687.13	$ 15.82	$ 2,105.59	$ 2,205.16
South Central	Family and Children	Newborn, 3-11 Months	104,247	$ 223.91	2.4%	5.7%	1.05	1.12	-5.3%	0.96	0.97	0.99	0.99	1.00	$ 0.21	$ 206.77	$ 222.66	$ 10.89	5.2%	$ 11.67	5.2%	2.0%	2.25%	$ 236.60	$ 256.88	$ 45.04	$ 1.04	$ 284.68	$ 302.96
South Central	Family and Children	Child, 1-18 Years	2,034,374	$ 102.79	3.3%	6.3%	1.07	1.14	-3.0%	0.94	0.95	1.00	1.00	1.00	$ 0.05	$ 100.85	$ 108.27	$ 10.89	4.5%	$ 11.67	4.5%	2.0%	2.25%	$ 121.45	$ 130.38	$ 13.43	$ 0.31	$ 135.19	$ 144.12
South Central	Family and Children	Adult, 19+ Years	285,291	$ 232.99	2.9%	5.9%	1.06	1.13	2.8%	0.97	0.97	1.01	1.01	1.00	$ -	$ 247.50	$ 264.57	$ 10.89	4.8%	$ 11.67	4.8%	2.0%	2.25%	$ 282.33	$ 301.85	$ 57.79	$ 1.33	$ 341.45	$ 360.97
South Central	Breast and Cervical Cancer	BCC, All Ages Female	2,880	$ 1,292.45	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	1.08	1.08	1.00	$ -	$ 1,572.30	$ 1,704.28	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,737.63	$ 1,883.77	$ 561.19	$ 12.92	$ 2,311.73	$ 2,457.87
South Central	LaCHIP Affordable Plan	All Ages	12,222	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	1.00	1.00	1.00	$ -	$ 115.68	$ 124.73	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.73	$ 148.44	$ 16.72	$ 0.43	$ 156.88	$ 167.60
South Central	HCBS Waiver	18 & Under, Male and Female	6,213	$ 1,368.00	2.0%	4.6%	1.04	1.10	0.5%	0.94	0.97	1.00	1.00	1.00	$ -	$ 1,349.97	$ 1,469.57	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,495.85	$ 1,628.48	$ 55.63	$ 1.28	$ 1,552.76	$ 1,685.39
South Central	HCBS Waiver	19+ Years, Male and Female	22,305	$ 521.48	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	1.00	1.00	1.00	$ -	$ 480.29	$ 522.01	$ 10.89	4.3%	$ 11.67	4.3%	2.0%	2.25%	$ 534.32	$ 580.88	$ 81.09	$ 1.87	$ 617.28	$ 663.84
South Central	Chisholm Class Members	Chisholm, All Ages Male & Female	16,290	$ 772.12	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	1.00	1.00	1.00	$ -	$ 749.15	$ 821.56	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 833.39	$ 913.96	$ 68.16	$ 1.57	$ 903.12	$ 983.69
South Central	Maternity Kickpayment	Maternity Kickpayment, All Ages	10,347	$ 4,429.47	0.0%	2.0%	1.00	1.04	2.5%	1.00	1.00	1.02	1.02	1.05	$ -	$ 4,650.05	$ 5,058.65	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 5,371.85	$ 5,602.40	$ 2,640.58	$ 60.78	$ 8,073.21	$ 8,303.76
North	SSI	Newborn, 0-2 Months	239	$ 19,659.26	0.4%	3.8%	1.01	1.06	-5.0%	1.00	1.00	0.91	0.92	1.00	$ 945.10	$ 18,120.97	$ 19,413.84	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 20,075.10	$ 21,505.54	$ 7,703.95	$ 177.33	$ 27,956.38	$ 29,386.81
North	SSI	Newborn, 3-11 Months	1,678	$ 4,031.32	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	0.97	0.97	1.00	$ 63.79	$ 3,991.93	$ 4,256.71	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,410.05	$ 4,702.48	$ 874.61	$ 20.13	$ 5,304.79	$ 5,597.21
North	SSI	Child, 1-18 Years	99,769	$ 296.46	3.0%	5.8%	1.06	1.12	3.7%	0.98	0.99	1.11	1.11	1.00	$ 2.39	$ 357.88	$ 382.54	$ 10.89	4.4%	$ 11.67	4.5%	2.0%	2.25%	$ 401.76	$ 429.51	$ 43.25	$ 1.00	$ 446.00	$ 473.76
North	SSI	Adult, 19+ Years	211,578	$ 640.82	2.8%	5.8%	1.06	1.12	0.5%	0.99	0.99	1.00	1.00	1.00	$ -	$ 673.41	$ 719.20	$ 10.89	4.5%	$ 11.67	4.5%	2.0%	2.25%	$ 746.28	$ 797.23	$ 173.18	$ 3.99	$ 923.45	$ 974.40
North	Family and Children	Newborn, 0-2 Months	32,218	$ 1,241.60	0.7%	4.1%	1.01	1.09	-4.4%	1.00	1.00	1.01	1.02	1.00	$ 46.33	$ 1,262.23	$ 1,352.97	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,408.49	$ 1,506.50	$ 572.83	$ 13.19	$ 1,994.51	$ 2,095.51
North	Family and Children	Newborn, 3-11 Months	80,049	$ 206.13	2.4%	5.8%	1.05	1.12	-4.9%	0.97	0.97	1.00	1.00	1.00	$ 0.21	$ 196.13	$ 213.33	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 229.23	$ 246.76	$ 32.15	$ 0.74	$ 262.11	$ 279.64
North	Family and Children	Child, 1-18 Years	1,586,038	$ 87.20	3.0%	6.2%	1.06	1.13	-1.1%	0.96	0.96	1.00	1.00	1.00	$ 0.05	$ 88.02	$ 94.43	$ 10.89	4.8%	$ 11.67	4.8%	2.0%	2.25%	$ 107.70	$ 115.53	$ 13.51	$ 0.31	$ 121.51	$ 129.34
North	Family and Children	Adult, 19+ Years	213,578	$ 219.68	2.8%	5.9%	1.06	1.13	2.2%	0.97	0.97	1.01	1.01	1.00	$ -	$ 231.41	$ 247.81	$ 10.89	4.9%	$ 11.67	5.0%	2.0%	2.25%	$ 265.00	$ 283.81	$ 59.76	$ 1.38	$ 326.14	$ 344.95
North	Breast and Cervical Cancer	BCC, All Ages Female	2,395	$ 1,292.45	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	1.08	1.08	1.00	$ -	$ 1,572.30	$ 1,704.28	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,737.63	$ 1,883.77	$ 575.28	$ 13.24	$ 2,326.15	$ 2,472.29
North	LaCHIP Affordable Plan	All Ages	6,545	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	1.00	1.00	1.00	$ -	$ 115.68	$ 124.73	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.73	$ 148.44	$ 16.73	$ 0.43	$ 156.89	$ 167.60
North	HCBS Waiver	18 & Under, Male and Female	3,944	$ 1,368.00	2.0%	4.6%	1.04	1.10	0.5%	0.94	0.97	1.00	1.00	1.00	$ -	$ 1,349.97	$ 1,469.57	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,495.85	$ 1,628.48	$ 56.24	$ 1.29	$ 1,553.38	$ 1,686.01
North	HCBS Waiver	19+ Years, Male and Female	16,992	$ 521.48	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	1.00	1.00	1.00	$ -	$ 480.29	$ 522.01	$ 10.89	4.3%	$ 11.67	4.3%	2.0%	2.25%	$ 534.32	$ 580.88	$ 81.16	$ 1.87	$ 617.35	$ 663.91
North	Chisholm Class Members	Chisholm, All Ages Male & Female	16,296	$ 772.12	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	1.00	1.00	1.00	$ -	$ 749.15	$ 821.56	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 833.39	$ 913.96	$ 68.62	$ 1.58	$ 903.59	$ 984.16
North	Maternity Kickpayment	Maternity Kickpayment, All Ages	8,077	$ 4,646.89	0.0%	2.0%	1.00	1.04	-0.2%	1.00	1.00	1.01	1.02	1.02	$ -	$ 4,780.66	$ 4,986.56	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 5,295.00	$ 5,522.56	$ 2,591.04	$ 59.64	$ 7,945.67	$ 8,173.23

MARSH & McLENNAN COMPANIES

Appendix C: Statewide Impact by COA from Removing the LaHIPP Program

	Base Data		LaHIPP Base Data		Base Data without LaHIPP		
COA Description	CY 2013 MMs or Deliveries	PMPM or Cost per Delivery	CY 2013 MMs or Deliveries	PMPM or Cost per Delivery	CY 2013 MMs or Deliveries	PMPM or Cost per Delivery	PMPM % Change
SSI	1,358,223	$604.69	6,217	$209.79	1,352,006	$606.51	0.30%
Family and Children	9,226,622	$134.62	15,795	$41.30	9,210,827	$134.78	0.12%
Breast and Cervical Cancer	12,936	$1,291.59	10	$173.89	12,926	$1,292.45	0.07%
LaCHIP Affordable Plan	38,711	$120.14	-	$-	38,711	$120.14	0.00%
HCBS Waiver	108,183	$704.37	4,133	$501.96	104,050	$712.42	1.14%
Chisholm Class Members	64,569	$774.94	1,021	$950.64	63,548	$772.12	-0.36%
Maternity Kick Payment	38,617	$4,755.22	36	$2,548.60	38,581	$4,757.30	0.04%
Total	**10,809,244**	**$221.53**	**27,176**	**$187.53**	**10,782,068**	**$221.62**	**0.04%**

Appendix D: Statewide Impact by Rating Category from Mandating the Voluntary Opt-Out Populations

COA Description	Rate Cell Description	MMs	Target PMPM	Voluntary Opt-out Impact	Revised Target PMPM
SSI	Newborn, 0-2 Months	902	$22,649.82	-8.21%	$20,790.32
SSI	Newborn, 3-11 Months	6,529	$4,681.23	-2.67%	$4,556.26
SSI	Child, 1-18 Years	401,215	$390.44	8.50%	$423.64
SSI	Adult, 19+ Years	943,360	$835.78	0.17%	$837.21
Family and Children	Newborn, 0-2 Months	157,338	$1,365.85	2.75%	$1,403.46
Family and Children	Newborn, 3-11 Months	382,745	$239.82	-0.38%	$238.92
Family and Children	Child, 1-18 Years	7,529,383	$116.71	0.20%	$116.94
Family and Children	Adult, 19+ Years	1,141,361	$284.46	0.68%	$286.39
Breast and Cervical Cancer	BCC, All Ages Female	12,926	$1,681.21	7.70%	$1,810.70
LaCHIP Affordable Plan	All Ages	38,711	$142.65	0.31%	$143.08
HCBS Waiver	18 & Under, Male and Female	23,469	$1,562.16	0.00%	$1,562.16
HCBS Waiver	19+ Years, Male and Female	80,581	$557.60	0.00%	$557.60
Chisholm Class Members	Chisholm, All Ages Male & Female	63,548	$873.67	0.00%	$873.67
Maternity Kick Payment	Maternity Kick Payment, All Ages	38,581	$5,489.32	1.58%	$5,575.99
Total		**10,782,068**	**$267.33**	**0.93%**	**$269.81**

Appendix E: Bayou Health Rate Certification Effective July 1, 2015 through January 31, 2016

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MERCER
MAKE TOMORROW, TODAY

Ms. Jen Steele
Medicaid Deputy Director
Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70821

August 11, 2015

Subject: Louisiana Bayou Health Program – Full Risk-Bearing Managed Care Organization Rate Development and Actuarial Certification for the Period July 1, 2015 through January 31, 2016

Dear Ms. Steele:

The Louisiana Department of Health and Hospitals (DHH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for the State of Louisiana's Bayou Health program for the period of July 1, 2015 through January 31, 2016. This certification includes the addition of Full Medicaid Pricing (FMP) for ambulance and hospital-based physician services, and replaces the capitation rate ranges certified in the January 31, 2015 letter for the period February 1, 2015 through January 31, 2016.

The Bayou Health program began February 1, 2012, and operated under two separate managed care paradigms for the first three years of the program. The Bayou Health Prepaid program operated under an at-risk capitated arrangement, and the Shared Savings program was an enhanced Primary Care Case Management (ePCCM) program. Effective February 1, 2015, Bayou Health will begin operating as an at-risk capitated program only.

This letter presents an overview of the methodology used in Mercer's managed care rate development for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS). This rate development process used Medicaid fee-for-service (FFS) medical and pharmacy claims, Bayou Health Shared Savings claims experience, and Bayou Health Prepaid encounter data. It resulted in the development of a range of actuarially sound rates for each rate cell. The capitation rate ranges are summarized in Appendix A and represent payment in full for the covered services and CMS Consultation guide is included in Appendix N.

Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government mandated assessments, fees, and taxes, and the cost of capital. Note: Please see pages 8-9 of the August 2005, Actuarial Certification of Rates for Medicaid Managed Care Programs, from the American Academy of Actuaries, http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.

Rate Methodology

Overview

Capitation rate ranges for the Bayou Health program were developed in accordance with rate-setting guidelines established by CMS. For rate range development for the Bayou Health managed care organizations (MCOs), Mercer used calendar year 2013 (CY13) Medicaid FFS medical and pharmacy claims, Bayou Health Shared Savings claims experience, and Bayou Health Prepaid encounter data. Restrictions were applied to the enrollment and claims data so that it was appropriate for the populations and benefit package defined in the contract.

Mercer reviewed the data provided by DHH and the Prepaid and Shared Savings plans for consistency and reasonableness and determined that the data are appropriate for the purpose of setting capitation rates for the MCO program. The data certification shown in Appendix L has been provided by DHH, and its purpose is to certify the accuracy, completeness, and consistency of the base data.

Adjustments were made to the selected base data to match the covered populations and Bayou Health benefit packages for rating year 2015 (RY15). Additional adjustments were then applied to the base data to incorporate:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data.
- Provision for incurred-but-not-reported (IBNR) claims.
- Financial adjustments to encounter data for under-reporting.
- Trend factors to forecast the expenditures and utilization to the contract period.
- Changes in benefits covered by managed care.
- Addition of new populations to the Bayou Health program.
- Opportunities for managed care efficiencies.
- Administration and underwriting profit/risk/contingency loading.

In addition to these adjustments, DHH takes two additional steps in the matching of payment to risk:

- Application of maternity supplemental (kick) payments.
- Application of risk-adjusted regional rates.

The resulting rate ranges for each individual rate cell were net of Graduate Medical Education (GME) payments to teaching hospitals provided in the Louisiana Medicaid State Plan. Appendix M shows the full rate development from the base data as shown in the data book released by the State, dated January 31, 2015, and applies all the rate setting adjustments as described in this letter.

Bayou Health Populations

Covered Populations

In general, the Bayou Health program includes individuals classified as Supplemental Security Income (SSI), Family & Children, Breast and Cervical Cancer (BCC), and LaCHIP Affordable Plan (LAP) as mandatory or voluntary opt-out populations. Voluntary opt-in populations include Home- and Community-Based Services (HCBS) waiver participants and Chisholm Class Members (CCM).

Chisholm Class Members

Effective February 1, 2015, members of Louisiana's Chisholm class will be permitted to participate in Bayou Health on a voluntary opt-in basis. Previously, membership in the Chisholm class would make a recipient ineligible for Bayou Health.

Chisholm refers to a class action lawsuit (*Chisholm v. Hood*) filed in 1997. CCMs are defined as all current and future recipients of Medicaid in the State of Louisiana, under age 21, who are now or will in the future be placed on the Office of Citizens with Developmental Disabilities' Request for Services Registry.

LaHIPP Population

Effective February 1, 2015, Bayou Health will include individuals covered by the Louisiana's Health Insurance Premium Payment (LaHIPP) Program. This program pays for some or all of the health insurance premiums for an enrollee if they have insurance available through someone in the family and are enrolled in Medicaid. The program also covers out of pocket expenses incurred by the enrollee (Medicaid is the secondary payer).

Premiums will continue to be paid by DHH, but out of pocket expenses incurred by the enrollee will be the responsibility of the MCO. LaHIPP is not a category of eligibility. Enrollees in this program are eligible under the other categories of aid (COA) and their experiences are included in the applicable COA and Rate Cell combination for purposes of developing the capitation rate range.

Excluded Populations

The following individuals are excluded from participation in the Bayou Health program:

- Medicare-Medicaid Dual Eligible Beneficiaries.
- Qualified Medicare Beneficiaries (QMB) (only where State only pays Medicare premiums).
- Specified Low-income Medicare Beneficiaries (SLMB) (where State only pays Medicare premiums).
- Medically Needy Spend-Down Individuals.
- Individuals residing in Long-term Care Facilities (Nursing Home, Intermediate Care Facility/Developmentally Disabled (ICF/DD)).
- Individuals enrolled in the Program for All-inclusive Care for the Elderly (PACE).
- Individuals only eligible for Family Planning services.
- Individuals enrolled in the Greater New Orleans Community Health Connection (GNOCHC) Demonstration waiver.

Appendix B encompasses a comprehensive list of Bayou Health's covered and excluded populations.

Rate Category Groupings

Rates will vary by the major categories of eligibility. Furthermore, where appropriate, the rates within a particular category of eligibility are subdivided into different age bands to reflect differences in risk due to age. In addition, due to the high cost associated with pregnancies, DHH will pay a maternity kick payment to the MCOs for each delivery that takes place. Table 1 shows a list of the different rate cells for each eligibility category including the maternity kick payments.

Table 1: Rate Category Groupings

COA Description	Rate Cell Description
SSI	Newborns, 0-2 Months of Age
	Newborns, 3-11 Months of Age
	Child, 1-18 Years of Age
	Adult, 19+ Years of Age

COA Description	Rate Cell Description
Family & Children	Newborns, 0-2 Months of Age
	Newborns, 3-11 Months of Age
	Child, 1-18 Years of Age
	Adult, 19+ Years of Age
BCC	BCC, All Ages
LAP	LAP, All Ages
HCBS	Child, 0-18 Years of Age
	Adult, 19+ Years of Age
CCM	CCM, All Ages
Maternity Kick Payment	Maternity Kick Payment
Early Elective Delivery Kick Payment	EED Kick Payment

Region Groupings

For rating purposes, Louisiana has been split into four different regions. Table 2 lists the associated parishes for each of the four regions.

Table 2: Region Groupings

Region Description	Associated Parishes (Counties)
Gulf	Assumption, Jefferson, Lafourche, Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John, St. Mary, and Terrebonne
Capital	Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, St. Tammany, Tangipahoa, Washington, West Baton Rouge, and West Feliciana
South Central	Acadia, Allen, Avoyelles, Beauregard, Calcasieu, Cameron, Catahoula, Concordia, Evangeline, Grant, Iberia, Jefferson Davis, Lafayette, Lasalle, Rapides, St. Landry, St. Martin, Vermilion, Vernon, and Winn
North	Bienville, Bossier, Caddo, Caldwell, Claiborne, DeSoto, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Natchitoches, Ouachita, Red River, Richland, Sabine, Tensas, Union, Webster, and West Carroll

Bayou Health Services

Covered Services

Appendix C lists the services that the Bayou Health MCOs must provide. The MCOs also have the ability to develop creative and innovative solutions to care for their members (i.e., provide other cost-effective alternative services) as long as the contractually-required Medicaid services are covered. Costs of alternative services are expected to be funded through savings on the contractually-required services for which these services are a cost-effective substitute.

New Services

Effective February 1, 2015, DHH has decided to incorporate services covered historically by FFS in the Bayou Health program. The following services were previously excluded from the Bayou Health program and now are included:

- Hospice services.
- Personal care services for ages 0-20.
- Non-Emergent Medical Transportation (NEMT) services (non-covered services).

Hospice and Personal Care services claims are all captured in Legacy Medicaid/FFS claims. Therefore, the impact of Hospice and Personal Care services can be calculated by referencing Attachment 1 of the Bayou Health Data Book released by the State, dated January 31, 2015.

Additionally, NEMT will be the responsibility of the Bayou Health MCO, even if the recipient is being transported to a Medicaid-covered service that is not a Bayou Health-covered service. Previously, Prepaid enrollee NEMT to Bayou Health excluded services would have been FFS. Mercer has created an adjustment for the Prepaid NEMT Encounters to account for this addition and the impact can be found in Appendix D. This additional service cannot be distinguished for Shared Savings/FFS claims because all NEMT services for these populations were covered under FFS. The impact of the additional services are fully captured for the Shared Savings and FFS populations in the NEMT experience on Attachment 1 of the Bayou Health Data Book released by the State, dated January 31, 2015.

Behavioral Health Mixed Services Protocol

In the Request for Proposals (RFP) issued by the State for the Bayou Health program to be effective February 1, 2015, Behavioral Health services are divided into two levels: basic and specialized. Basic Behavioral Health services will be the responsibility of Bayou Health MCOs. Basic services include:

- General hospital inpatient services, including acute detoxification.

- General hospital emergency room (ER) services, including acute detoxification.
- Federally Qualified Health Center (FQHC)/Rural Health Center (RHC) encounters that do not include any service by a specialized behavioral health professional.
- Professional services, excluding services provided by specialized behavioral health professionals.

Specialized Behavioral Health services will be identified primarily based on provider type. Any service provided by behavioral health specialists, as well as behavioral health facilities are considered Specialized Behavioral Health. Appendix E summarizes the adjustment that was applied to each Basic Behavioral Health service category.

Behavioral health pharmacy costs will remain the responsibility of the Bayou Health plans, regardless of the prescribing doctor's specialty. Therefore, no adjustment to pharmacy costs are required.

Excluded Services

Bayou Health MCOs are not responsible for providing acute care services and other Medicaid services not identified in Appendix C, including the following services:

- Applied Behavioral Analysis.
- Dental services with the exception of Early and Periodic Screening & Diagnostic Treatment (EPSDT) varnishes provided in a primary care setting.
- ICF/DD services.
- Personal Care services for those ages 21 and older.
- Nursing Facility services.
- School-based Individualized Education Plan services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures including school nurses.
- HCBS waiver services.
- Specialized Behavioral Health.
- Targeted Case Management services.
- Services provided through DHH's Early-Steps Program.

Data Adjustments

IBNR Claims

Completion factors were developed to incorporate consideration for any outstanding claims liability. The paid through date for the IBNR factor development is February 28, 2014 (2 months of runout).

To establish the completion factors for the Shared Savings/Legacy Medicaid FFS data, claims were grouped into three COA and seven main completion service categories. All remaining service categories were grouped into the other service category. Completion category mapping is provided in Appendix C. Note that the BCC and CCM populations utilized SSI completion factors and the LAP population utilized Family & Children completion factors, as these populations are expected to exhibit similar completion patterns. Appendix F-1 summarizes the completion factors adjustment that was applied to the Shared Savings/Legacy Medicaid FFS data.

Encounter claim completion factors, developed separately for each Prepaid plan, were compared to completion factors provided by the Prepaid plan actuaries and summarized by completion category of service. Appendix F-2 summarizes the completion factors adjustment that was applied to the Prepaid encounter data. Mercer determined that Prepaid encounter claims categorized as "Prescribed Drugs" for all populations and "Other" for the Family & Children and LAP populations only, is deemed to be complete, thus a 0% IBNR adjustment is applied. All other IBNR adjustments shown as 0.0% in Appendices F-1 and F-2 are due to rounding.

Under-Reporting

Under-reporting adjustments were developed by comparing encounter data from the Medicaid management information system (MMIS) to financial information provided by the Prepaid plans. This adjustment was computed and applied on a plan basis resulting in an overall adjustment of 3.6%. Note this adjustment does not apply to the Shared Savings claims nor Legacy Medicaid/FFS data. This adjustment is included in the data book released by the State, dated January 31, 2015.

Third-Party Liabilities

All claims are reported net of third party liability, therefore no adjustment is required.

Fraud and Abuse Recoveries

DHH provided data related to fraud and abuse recoveries on the Shared Savings and Legacy FFS. The total adjustment applied was -0.1%. Prepaid plans included fraud and abuse recoveries in their financial reports. These recoveries were included in the development of the under-reporting adjustment.

Co-Payments

Co-pays are only applicable to prescription drugs. Pharmacy claims are reported net of any co-payments so no additional adjustment is necessary.

Disproportionate Share Hospital Payments

Disproportionate share hospital (DSH) payments are made outside of the MMIS system and have not been included in the capitation rates.

Fee Schedule Adjustments

Fee Changes

These capitation rates reflect changes made by DHH to the fee schedules used in the FFS program. The first of these changes, effective February 1, 2013, was a 1% cut in fees paid to non-rural, non-state hospitals. This 1% cut also applied to physician services, except for procedure codes affected by Section 1202 of the Affordable Care Act (ACA), when performed by a physician eligible for the enhanced payment rate. Fee changes also include estimation of cost settlements and reflect the most up to date cost settlement percentages for each facility. For most non-rural facilities, the cost settlement percentage is 66.46%; however, some facilities are settled at different amounts. Rural facilities are cost settled at 110%. The Fee Schedule adjustments for Prepaid and Shared Savings/FFS are different primarily because the Shared Savings adjustment includes the impact of removing GME costs. A detailed breakdown of the fee changes by fee type (Inpatient, Outpatient, and Physician) is provided in Tables 3 through 7.

Table 3: Total Inpatient Fee Change Impact

Program	Historical Cost	Adjusted Cost	Difference	% Change
FFS/Shared	$241,618,333	$231,450,795	$(10,167,538)	-4.2%
Encounter	$242,871,303	$245,575,202	$2,703,899	1.1%
Total:	**$484,489,636**	**$477,025,997**	**$(7,463,639)**	**-1.5%**

Table 4: Total Outpatient Fee Change Impact

Program	Historical Cost	Adjusted Cost	Difference	% Change
FFS/Shared	$144,561,703	$145,753,679	$1,191,976	0.8%
Encounter	$163,170,757	$178,679,937	$15,509,181	9.5%
Total:	**$307,732,460**	**$324,433,616**	**$16,701,157**	**5.4%**

Table 5: Total Physician Fee Change Impact (does not reflect reduction of Affordable Care Act {ACA}–enhanced payments)

Program	Historical Cost	Adjusted Cost	Difference	% Change
FFS/Shared	$317,853,687	$317,707,582	$ (146,105)	0.0%
Encounter	$262,096,884	$261,889,654	$ (207,147)	-0.1%

Program	Historical Cost	Adjusted Cost	Difference	% Change
Total:	**$579,950,571**	**$579,597,236**	**$(353,252)**	**-0.1%**

Table 6: Total Fee Change Impact for Other Claims (includes pharmacy, lab/radiology, FQHC/RHC, and other services)

Program	Historical Cost	Adjusted Cost	Difference	% Change
FFS/Shared	$516,113,110	$516,113,110	$(0)	0.0%
Encounter	$472,643,308	$472,643,391	$(0)	0.0%
Total:	**$988,756,418**	**$988,756,501**	**$(0)**	**0.0%**

Table 7: Total Fee Change Impact for All Claims (excluding ACA Primary Care Providers {PCP} Enhanced Payments)

Program	Historical Cost	Adjusted Cost	Difference	% Change
FFS/Shared	$1,220,146,833	$1,211,025,166	$ (9,121,667)	-0.7%
Encounter	$1,140,782,252	$1,158,788,184	$18,005,932	1.6%
Total:	**$2,360,929,085**	**$2,369,813,350**	**$8,884,266**	**0.4%**

Hospital Privatization

During 2013, nine state hospitals were affected by privatization, with seven privatizing and two closing. They are listed below:

Privatizing

- E.A. Conway
- Huey P. Long
- Leonard J. Chabert
- LSU Shreveport
- Medical Center of LA – New Orleans
- University Medical Center Lafayette
- Washington St. Tammany Regional Medical Center

Closing

- W.O. Moss Regional Medical Center
- Earl K. Long

As a result of this privatization, they are no longer paid for services based on the state hospital fee schedule, but rather on the non-state, non-rural fee schedule. Similarly, reimbursement for

cost-based services for these hospitals is now based on the 66.46% cost settlement percentage for non-state, non-rural hospitals, rather than the 90% cost-settlement percentage applicable to state hospitals. The utilization in the facilities that are closing was assumed to be absorbed by other facilities in the regions and claims were adjusted accordingly.

For Shared Savings/FFS inpatient hospital claims, the inpatient settlements received as a state hospital were removed from the rate calculation since they are not paid to non-state hospitals. The claims were then re-priced using the July 1, 2014 per diems provided by DHH. For the two hospitals that are closing, W.O. Moss Regional Medical Center and Earl K. Long, DHH provided Mercer guidance on which hospitals were expected to absorb their utilization. W.O. Moss Regional Medical Center will be absorbed by Lake Charles Memorial and Earl K. Long will be absorbed by Our Lady of the Lake. For Encounter claims, the ratio between historical per diems and current per diems were used for claims re-pricing.

For outpatient hospital claims, the historical claims were adjusted for differences between the state hospital fee schedule and the general hospital fee schedule. Outpatient cost-based services were re-priced based on cost-to-charge ratios (CCRs) provided by DHH, which reflect costs associated with the Prepaid plans claims. The overall claims dollar impact of this adjustment is shown in Tables 8 and 9.

Table 8: Inpatient Impact of LSU Hospital Privatization*

Program	Historical Cost	Adjusted Cost	Difference	% Change
FFS/Shared	$15,196,381	$13,793,540	$ (1,402,840)	-9.2%
Encounter	$22,826,670	$23,165,474	$338,804	1.5%
Total:	**$38,023,050**	**$36,959,014**	**$(1,064,036)**	**-2.8%**

* Change in FFS/Shared includes removal of GME costs.

Table 9: Outpatient Impact of LSU Hospital Privatization

Program	Historical Cost	Adjusted Cost	Difference	% Change
FFS/Shared	$12,910,923	$10,663,597	$ (2,247,325)	-17.4%
Encounter	$25,564,646	$23,390,499	$ (2,174,147)	-8.5%
Total:	**$38,475,568**	**$34,054,096**	**$ (4,421,472)**	**-11.5%**

Table 10 summarizes the overall fee schedule adjustment by COA that was applied to the Prepaid encounter and Shared Savings/FFS claims data.

Table 10: Fee Schedule Adjustment

Prepaid Fee Schedule Adjustment	
COA Description	**Rate Impact**
SSI	1.5%
Family & Children	1.7%
BCC	0.6%
LAP	2.3%
HCBS	0.0%
CCM	0.0%
Maternity Kick Payment	1.7%
Early Elective Delivery (EED) Kick Payment	1.7%
Total	**1.6%**

Shared Savings/FFS Fee Schedule Adjustment	
COA Description	**Rate Impact**
SSI	-1.4%
Family & Children	-0.8%
BCC	-0.3%
LAP	0.8%
HCBS	0.7%
CCM	0.7%
Maternity Kick Payment	-0.6%
EED Kick Payment	-0.6%
Total	**-0.8%**

Full Medicaid Pricing

Beginning in April 2014, DHH implemented a series of program changes to ensure consistent pricing in the Medicaid program for hospital services, including inpatient hospital, outpatient hospital, hospital-based physician, and ambulance services. This change required the use of FMP in the calculation of per member per month (PMPM) payments to MCOs. DHH expects that this rate increase will lead to increased payments to those providers contracting with the MCOs to maintain and increase access to inpatient hospital, outpatient hospital, hospital-based physician, and ambulance services to the enrolled Medicaid populations. Mercer and the State reviewed the aggregate funding levels for these services between the base period and the contract period and determined that an addition to the historical data was necessary in order to ensure the capitation rate ranges reflect adequate statewide pricing levels. Separate adjustments were made to each of the four services to capture the full impact of statewide funding.

FMP adjustments were implemented for inpatient and outpatient services effective April 2014. Physician and ambulance FMP adjustments are effective July 2015.

Inpatient Hospital Services

For the Prepaid encounter and the Shared Savings/FFS data, inpatient service costs were increased by 65.1% and 59.9%, respectively. Mercer relied upon an analysis of Medicare diagnosis related group equivalent pricing of Medicaid services provided by DHH. For the Prepaid encounter, this analysis was done for the population served by the three Prepaid plans in aggregate. A separate analysis was done for the Shared Savings/FFS population. The

analyses relied upon encounter and Shared Savings/FFS data incurred from July 2012 to June 2013 and compared the adjusted Medicare payments to the Medicaid payment on a per discharge basis at each hospital. The Medicare payments were adjusted to reflect the treatment of Medicaid patients and reflected the state fiscal year 2014 (SFY14) reimbursement schedule. The SFY13 Medicaid payments were adjusted to reflect fee changes effective in SFY14 and payments made outside of the claims system (outlier payments). Mercer applied the ratio between the two payments to the base data at a hospital-specific level.

Outpatient Hospital Services

For the Prepaid encounter and the Shared Savings/FFS data, outpatient service costs were increased by 52.7% and 56.3%, respectively. The outpatient increase was developed according to the State Plan using cost to charge ratios, which used reported costs and billed charges by hospital. The cost to charge ratios supplied by DHH were reported on hospital fiscal year bases, which varied by hospital from 2/28/2013 to 12/31/2013. The billed charges originated from the Prepaid encounter and the Shared Savings/FFS base data. Mercer applied the ratio between the base data and cost estimates at a hospital level to develop the outpatient component of the FMP.

Hospital-Based Physician Services

For Prepaid encounter and Shared Savings/FFS experience, hospital-based physician services meeting the State Plan's criteria for FMP were increased by 83.2% and 105.6%, respectively. Mercer performed an analysis of hospital-based physician services provided at participating facilities by participating physicians compared to the average commercial rates for the same services according to the State Plan methodology. The average commercial rates are maintained by DHH and updated periodically. For state-owned or operated entities, average commercial rate factors are updated annually. DHH provided state-owned conversion factors for calendar year 2015. For non-state owned or operated entities, the average commercial rate factors are indexed to Medicare rates and updated every 3 years. DHH provided the latest available non-state factors, which were last updated as recently as April 2013. The scheduled update of these factors is currently underway and expected to be completed by the end of calendar year 2015.

Ambulance Services

For Prepaid encounter and Shared Savings/FFS experience, ambulance services meeting the State Plan's criteria for FMP were increased by 49.2% and 44.4%, respectively. Mercer performed an analysis of ambulance services utilized by Medicaid enrollees according to the State Plan using Medicare fee schedules and average commercial rates as a percentage of Medicare. Ambulance providers were classified as either Large Urban Governmentals (LUG) or non-LUGs. LUGs have historically received 100% of the gap between average commercial rate

and the Medicaid fee schedule while non-LUGs have historically received 17.35% of the gap. Mercer developed increases using these assumed funding levels. Average commercial rates as a percentage of Medicare were provided by DHH and were determined based on SFY12 claims. According to the State Plan, average commercial rates are updated every three years. The next update is anticipated to occur before the end of calendar year 2015.

ACA PCP

Under Section 1202 of the ACA, state Medicaid programs were required to increase payments to PCPs in 2013 and 2014. This requirement expires on December 31, 2014. As a result, 2013 Bayou Health encounter and FFS claims were adjusted to reflect the decrease in PCP payment rates between 2013 and 2015. The reduction, applied at the COA level is based on adjusting the provider fee schedule from the enhanced ACA rate to the Medicaid rate set by DHH. For the Prepaid Encounters, the enhanced payment data was under-reported at the time Mercer requested data as Prepaid health plans were still reprocessing some of the enhanced claims. Discussions were held with each of the existing Prepaid health plans to make sure that Mercer was identifying these claims appropriately. For detail on the adjustment applied to these claims, see Appendices G1-G2.

Table 11 summarizes the overall adjustment by COA that was applied to the Prepaid encounter and Shared Savings/FFS claims data.

Table 11: ACA PCP Adjustment

Prepaid Encounter ACA PCP Carve-Out	
COA Description	**Rate Impact**
SSI	-1.3%
Family & Children	-3.9%
BCC	-0.7%
LAP	-4.3%
HCBS	0.0%
CCM	0.0%
Maternity Kick Payment	0.0%
EED Kick Payment	0.0%
Total	**-2.4%**

Shared Savings/FFS ACA PCP Carve-Out	
COA Description	**Rate Impact**
SSI	-1.4%
Family & Children	-4.7%
BCC	-0.7%
LAP	-5.1%
HCBS	-0.7%
CCM	-0.9%
Maternity Kick Payment	0.0%
EED Kick Payment	0.0%
Total	**-3.1%**

Program Changes

The following adjustments were developed for known program changes as of December 31, 2014.

Act 312

Effective January 1, 2014, Act 312 requires that when medications are restricted for use by an MCO using a step therapy or fail first protocol, the prescribing physician shall be provided with, and have access to, a clear and convenient process to expeditiously request an override of such restrictions from the MCO. The MCO is required to grant the override under certain conditions. Mercer reviewed this new requirement and estimated the impact of this change to be an increase of approximately 3% of pharmacy costs.

EED

Beginning February 2015, facility and delivering physician costs for EEDs will not be covered under the Bayou Health program. MCOs receive an EED Kick Payment for deliveries that occur prior to 39 weeks for reasons that are not medically indicated in the Louisiana Electronic Event Registration System (LEERS) maintained by the Office of Public Health/Vital Records. Deliveries that occur prior to 39 weeks for reasons that are medically indicated in LEERS will receive the Maternity Kick Payment. Mercer identified the average facility and delivering physician costs included in the Maternity Kick Payment by region and removed those costs to create the EED Kick Payment. Table 12 shows the EED adjustment and reduction amount by region in the low and high scenarios. The resulting EED Kick Payment is equal to the Maternity Kick Payment plus the reduction amount in Table 12 and is shown in Appendix A.

Table 12: Early Elective Delivery Rate Reduction

Early Elective Delivery Rate Reduction			
Region Description	**Reduction (%)**	**Reduction – Low Cost per Delivery**	**Reduction – High Cost per Delivery**
Gulf	34.3	$(3,703.28)	$(3,858.92)
Capital	43.3	$(2,832.60)	$(2,951.64)
South Central	41.2	$(2,914.86)	$(3,037.36)
North	38.0	$(3,164.81)	$(3,297.82)
Total	**38.9**	**$(3,167.07)**	**$(3,300.16)**

Retro-Active Eligibility Adjustment

Beginning in February 2015 members granted retro-active eligibility will be capitated retro-actively, based on their eligibility for Bayou Health, for up to 12 months prior to enrollment in an MCO. The MCO selected by these members will then receive one capitation payment per month of retro-active enrollment, and will be liable for all claims incurred during this retro-active

eligibility period. Mercer developed an adjustment factor to apply to the base data in the capitation rate development. Mercer did not apply any savings adjustments to the retro-active period claims in the development of these factors because the MCO will have no ability to manage utilization during the retro-active period.

The retro-active eligibility adjustment was developed as an increase to the capitation rates set for all members, meaning that the capitation payment is higher than otherwise required on non-retro-active member months (MMs). Retro-active enrollment in any given rate cell will generate the same capitation payment per month to the MCO as any other enrollee in that same rate cell. The factors were developed at a rate cell level on a statewide basis (i.e., all regions used the same factors). The calculation relied upon retro-active claims PMPM, unique enrollee counts, and the average duration to develop the expected increase to Bayou Health claims.

Mercer reviewed the average duration of enrollees who were retro-actively enrolled during 2013 using data from July 2012 to December 2013. From August 2012 to May 2013, DHH performed additional enrollment review processes, which caused the average duration of retro-active enrollment to increase significantly over normal levels. After May 2013, DHH returned to normal enrollment review processes and the average duration of enrollment decreased significantly. DHH confirmed that they do not foresee a need for implementing this additional review process in the future and expect the enrollment patterns to be consistent with those observed in the second half of 2013. Mercer relied upon July through December 2013 enrollment lags to develop an average durational assumption by COA and is shown in Appendix H-1.

In some rate cells, the retro-active claims PMPM was below the base data claims PMPM. This generated an adjustment factor less than 1.0. The decision was made to not use a factor less than 1.0 on any rate cell. These implied factors (calculated) and final factors (used) are supplied in Appendix H-2.

Table 13 summarizes the overall adjustment by rate cell for retro-active eligibility.

Table 13: Retro-Active Eligibility Adjustment

Retro-Active Eligibility Adjustment		
COA Description	**Rate Cell Description**	**Adjustment (%)**
SSI	0-2 Months	0.0
SSI	3-11 Months	0.0
SSI	Child 1-18	0.0
SSI	Adult 19+	0.5

Retro-Active Eligibility Adjustment		
Family & Children	0-2 Months	0.0
Family & Children	3-11 Months	0.0
Family & Children	Child 1-18	0.0
Family & Children	Adult 19+	1.7
BCC	BCC, All Ages	7.5
LAP	LAP, All Ages	0.0
HCBS	Child 0-18	0.0
HCBS	Adult 19+	0.0
CCM	CCM, All Ages	0.0
Maternity Kick Payment	Maternity Kick Payment	0.0
EED Kick Payment	EED Kick Payment	0.0
Total		**0.4**[1]

Rating Adjustments

Trend

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the cost of providing health care services in a future period. Mercer studied historical cost and utilization data for each of the three data sources incorporated in the capitation rates: Prepaid encounters, Shared Savings, and FFS. Trends were selected based on Louisiana experience, as well as national trend information.

Due to the relatively short history of managed care in Louisiana, as well as the bifurcated nature of the current Bayou Health program, Mercer's trend studies using Louisiana-specific data were limited in scope. Based on these studies, it was determined that the use of a single trend rate for all three data sources was best. In selecting these trends, there was reliance on national Medicaid trends as well as Louisiana-specific data.

Trends, delineated by utilization, unit cost, PMPM, and by population are shown in Appendices I1-I3.

[1] Revised from 0.7 to 0.4 due to a typographical error in the certification letter dated January 31, 2015.

PDHC Adjustments

The number of PDHC providers has grown throughout the State during 2014. In areas where centers have begun operation, there has been an increase in the total costs of enrollees whom utilize these services indicating that this population may have been historically under served by alternative services.

Due to the uneven distribution of PDHC providers in the State, each regional group has different proportions of members utilizing PDHC services. Mercer developed projected utilization per 1,000 MMs of PDHC-eligible members for each region based on the number of new facilities that will be operating during the rating period in that region. PDHC eligible members were simply defined as any enrollee in a child rate cell (SSI ages 0-18, Family & Children ages 0-18, LA CHIP, HCBS 0-19, and Chisholm). Any enrollees under the age of 21 are eligible for PDHC services, however, the data showed that virtually all users of this service were under the age of 19 and therefore no adjustment to the adult rate cells was warranted. Table 14 shows the summary of PDHC providers and estimated PDHC users by regions. To develop the estimated PDHC service cost, Mercer developed the PDHC cost per PDHC user per month. The estimation is based on the regional experience of PDHC providers during CY13. In the Gulf region, where there is little experience due to a lack of providers, an average statewide cost was used. The summary of estimated PDHC service cost per PDHC user per month and the estimated PDHC service cost due to the increased number of providers are shown in Table 15.

Table 14: Projected Number of PDHC Users

Projected Number of PDHC Users						
Region	**Existing Number of Providers[2]**	**Projected Number of Providers in Operation**	**Total PDHC Eligible MMs**	**Projected PDHC Users Per 1,000 MMs**	**Current Number of PDHC Users**	**Projected PDHC Users**
Gulf	1	2	2,357,462	0.076	5	179
Capital	5	6	2,121,456	0.481	901	1,020
South Central	1	3	2,315,409	0.173	176	401
North	3	5	1,829,787	0.421	228	770

[2] Based on December 2013 Experience.

Table 15: PDHC Adjustment

	PDHC Adjustment					
	PDHC Cost per Month[3]	**Projected Number of PDHC Users**	**Estimated Total PDHC Cost**	**PDHC Expenses in Base Data**	**Total Expenses for Category of Service "Other"**	**Program Change Factors for Category of Service "Other"**
	(A)	**(B)**	**(C)= (A) * (B)**	**(D)**	**(E)**	**(F)= ((C)-(D)) / (E)**
Gulf	$4,260.64	179	$764,123	$12,737	$681,410	110.3%
Capital	$4,559.67	1,020	$4,651,437	$4,249,502	$4,638,594	8.7%
South Central	$3,664.74	401	$1,470,474	$688,524	$2,213,236	35.3%
North	$4,557.50	770	$3,507,473	$1,099,006	$1,578,008	152.6%

Managed Care Adjustments

For those populations and services that had previously been excluded from Bayou Health, Mercer adjusted the capitation rates to reflect areas for managed care efficiency. Managed Care is able to generate savings by:

- Encouraging the use of preventive services so that acute conditions are not exacerbated to the point that requires a visit to the ER or hospitalization.
- Using alternatives to the ER for conditions that are non-emergent in nature.
- Increasing access and providing member education.
- Minimizing duplication of services.
- Hospital discharge planning to ensure a smooth transition from facility-based care to community resources and minimize readmissions.

Statewide managed care savings factors were applied to the HCBS and Chisholm class COAs. Additionally, durable medical equipment (DME) and NEMT costs for Shared Savings enrollees were adjusted as part of this rate setting, as these services were excluded from Bayou Health Shared Savings. Appendices J1-J2 summarizes the managed care savings adjustments that were applied to the Shared Savings/Legacy Medicaid FFS data.

[3] Based on PDHC users' CY13 experience. Gulf region does not have enough experience and the projection is based on the average of the other three regions' projections.

Shared Savings Rx claims

Under the Bayou Health Shared Savings program, plans had limited ability to manage prescription drug costs. In order to use the Shared Savings experience to set capitated rates, adjustments were needed to account for generic dispense rate (GDR) differences between the Prepaid and Shared Savings experience. For the Prepaid program, GDR was approximately 84%, compared to approximately 77% for Shared Savings and FFS. Mercer assumed the change in GDR would be zero the first month the rates are in effect, increasing evenly over the next three months until an 84% GDR is achieved in May 2015. Per section 6.33 of the Bayou Health RFP, MCOs are required to allow members 60 days to transition medications after enrollment in the MCO. The extra 30 days is to allow time for the MCO to identify the member for such a transition. This adjustment is a downward adjustment to the Shared Savings claims data. Mercer's analyzed Shared Savings prescription drug experience and compared it to the spending on similar therapeutic classes of drugs in the Prepaid program. Mercer determined that achieving the same GDR levels would result in savings of 13%-16%. After adjusting for phase-in, the savings for rating year 2015 is 11%-13%. Tables 16 and 17 detail the savings breakdown by COA, both without and with the phase in period.

Table 16: GDR Savings Adjustment – Without Phase In Period

Annualized Savings from Improvement in GDR						
Category of Service Description	**SSI**	**Family & Children***	**BCC**	**LAP**	**HCBS Waiver* (FFS)**	**Total**
	(%)	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**
Low Savings	4.2	21.2	0.0	29.9	6.7	13.3
High Savings	7.2	24.2	2.1	32.9	9.7	16.3

Table 17: GDR Savings Adjustment – With Phase-In Period

Savings from Improvement in GDR (w/Phase-in)						
Category of Service Description	**SSI**	**Family & Children***	**BCC**	**LAP**	**HCBS Waiver* (FFS)**	**Total**
	(%)	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**
Low Savings	3.5	17.7	0.0	24.9	5.6	11.1
High Savings	6.0	20.2	1.8	27.4	8.1	13.6

* In the above two tables, the HCBS waiver aid category is inclusive of CCMs.

Rx Rebates

FFS and Shared Savings claims were reduced 1.5% for Rx rebates collected by the MCO. This factor was developed using Prepaid plans experience as reported in financial statements provided to DHH. Prepaid Encounters were taken as net of drug rebates, so no adjustment was necessary.

Outliers

As part of the State Plan, inpatient hospitals receive an additional payment for high-cost stays for children under six, called outliers. These payments are for inpatient stays with a total cost to the hospital in excess of $150,000, where the cost is determined based on the hospital's Neonatal Intensive Care Unit (NICU) or Pediatric Intensive Care Unit (PICU)-specific cost-to-charge ratio (CCR). DHH makes payments to a maximum of $10 million, annually. As payment of outlier liability is the responsibility of Bayou Health MCOs, this additional $10 million was built into the rates based on the distribution by rate cell observed in SFY11 and SFY12. The most recent outlier information received was for SFY13 payments, which Mercer analyzed and determined the claims payment distribution to be an anomaly compared to SFY11 and SFY12 experience that was more consistently distributed. Thus, Mercer came to the decision that utilizing data from SFY11 and SFY12 would provide a more representative basis for the future claims distribution patterns. Outliers added an average cost of $0.93 PMPM to the base data used in rate setting. Table 18 details the impact of outliers on the rates by rate cell.

Table 18: Outliers Adjustment

Outlier claims to be added into Bayou Health from $10 million pool				
COA Description	**Rate Cell Description**	**CY13 MMs**	**Outlier PMPM**	**Outliers Total Adjustment**
SSI	Newborn, 0-2 Months	915	$945.10	$864,764
SSI	Newborn, 3-11 Months	6,651	$63.79	$424,266
SSI	Child, 1-18 Years	403,901	$2.39	$965,701
Family & Children	Newborn, 0-2 Months	157,724	$46.33	$7,307,552
Family & Children	Newborn, 3-11 Months	383,886	$0.21	$82,083
Family & Children	Child, 1-18 Years	7,542,938	$0.05	$355,635
Total*		**10,809,244**	**$0.93**	**$10,000,000**

* Totals includes MMs for all populations in Bayou Health.

GME

Mercer removed GME amounts in the FFS and Shared Savings data to be consistent with DHH's intention to continue paying GME amounts directly to the teaching hospitals. The

adjustment to remove GME from FFS and Shared Savings is part of the fee adjustment process for hospital claims. It is not explicitly calculated as a separate item. Mercer uses fee schedules that are net of GME in the fee adjustment process. Encounter data does not include GME payments and therefore no adjustment is required.

Data Smoothing

For certain rate cells, there were not enough MMs within each region to produce a statistically credible rate. For rate cells with less than 30,000 MMs per region, Mercer calculated a statewide capitation rate. Affected rate cells include:

- SSI newborns 0-1 years of age
- BCC, All Ages
- LAP, All Ages
- HCBS, All Ages
- CCM, All Ages

Voluntary Opt-In Adjustments

It is unclear at this time if there will be a material difference in the risk profile of the Opt-in population from the historical FFS population. Therefore, Mercer made no adjustments for selection risk in the development of the HCBS and CCM rates.

Non-Medical Expense Load

The actuarially sound capitation rate ranges developed include a provision for MCO administration and other non-medical expenses. Mercer reviewed historical Prepaid plan expense data and relied on its professional experience in working with numerous State Medicaid programs to develop the administrative load. The load for each rate cell was determined using a fixed and variable cost model. Under this model, a fixed administrative expense is attributed to each MM, which reflects program requirements, such as state-mandated staffing. Added to this is a variable administrative amount, based on claims volume. For pharmacy, 2% of claims cost was targeted, while 6.1% was targeted for medical. Maternity kick payment rate cells have only the variable medical administrative load. Previously, a percentage load was applied to all rate cells, with a smaller load being applied to maternity kick payments. This change results in retention loads that vary as a percentage by rate cell. See Appendix K for the percentage of premium allocated to total retention load in the rates. These percentages include all three components of retention: Administrative Costs, Margin, and Premium Tax. This methodology results in a higher allocation of administrative costs on the rate cells with higher utilization, which Mercer believes is more accurate in reflecting the drivers of plan administration requirements.

Mercer reviewed plan financial information provided by the Prepaid plans to develop administrative cost expectations. The development included allocations for increases in expenses including items such as additional case management due to claims volume and increases in staff compensation over time. The administrative development also included an expected increase in salary for the Behavioral Health Medical Director ($200,000), Program Integrity Officer ($100,000), and two Fraud and Abuse Investigators ($65,000 each). Final Administrative cost expectation was $21.78-$23.34 PMPM.

Additionally, provision has been made in these rates for a 2% risk margin calculated before applying any adjustment for FMP. Final rates also include provision for Louisiana's 2.25% premium tax.

Risk Adjustment

Risk adjustment will be applied to the rates in Attachment A to reflect differences in health status of the members served in each MCO using the Adjusted Clinical Groups (ACG) model. The risk adjustment process does not increase nor decrease the overall cost of the program, but can change the distribution across the various Bayou Health MCOs according to the relative risk of their enrolled members.

Federal Health Insurer Fee

Section 9010 of the ACA established a health insurance provider fee (HIPF), which applies to certain for-profit/tax-paying health insurers. For-profit Medicaid health plans are not exempt from the HIPF, which will become a cost of doing business that is appropriate to recognize in actuarially sound capitation rates.

At the time of this certification, many aspects of the calculation and application of this fee are not yet determined and/or finalized. These fees will be calculated and become payable sometime during the third quarter of 2016. As these fees are not yet defined by insurer and by market place, no adjustment has been made in the rate range development for the Bayou Health program. An adjustment and revised certification will be considered when the fee amount and impacted entities applicable to this rate period are announced in 2016.

Certification of Final Rate Ranges

In preparing the rate ranges shown in Attachment A, Mercer has used and relied upon enrollment, FFS claims, encounter data, reimbursement level, benefit design, and other information supplied by DHH and its fiscal agent. DHH, its fiscal agent, and the Prepaid plans are responsible for the validity and completeness of the data supplied. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In

our opinion they are appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies that the rates in Attachment A were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the managed care contract. Rate estimates provided are based upon the information available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rates and ranges developed by Mercer are actuarial projections of future contingent events. Actual Bayou Health MCO costs will differ from these projections. Mercer has developed these rates on behalf of DHH to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c), and in accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

Bayou Health MCOs are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges by Bayou Health MCOs for any purpose. Mercer recommends that any Bayou Health MCO considering contracting with DHH should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rate ranges before deciding whether to contract with DHH.

This certification letter assumes the reader is familiar with the Bayou Health Program, Medicaid eligibility rules, and actuarial rate-setting techniques. It is intended for DHH and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

If you have any questions on any of the information provided, please feel free to call me at +1 404 442 3358.

Sincerely,



Jaredd Simons, ASA, MAAA
Senior Associate Actuary

Appendix A: Bayou Health Capitation Rate Range

Region Description	COA Description	Rate Cell Description	CY13 MMs or Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
Gulf	SSI	0-2 Months	291	$29,176.77	$30,649.57
Gulf	SSI	3-11 Months	1,790	$5,329.02	$5,622.79
Gulf	SSI	Child 1-18	122,394	$384.88	$408.98
Gulf	SSI	Adult 19+	276,704	$1,016.63	$1,069.17
Gulf	Family & Children	0-2 Months	43,180	$1,719.26	$1,805.59
Gulf	Family & Children	3-11 Months	104,549	$247.21	$263.69
Gulf	Family & Children	Child 1-18	2,053,265	$120.02	$127.86
Gulf	Family & Children	Adult 19+	374,005	$321.77	$339.30
Gulf	BCC	BCC, All Ages	3,702	$2,180.61	$2,310.26
Gulf	LAP	LAP, All Ages	9,457	$154.51	$164.98
Gulf	HCBS	Child 0-18	6,826	$1,542.22	$1,671.56
Gulf	HCBS	Adult 19+	21,296	$603.34	$648.62
Gulf	CCM	CCM, All Ages	15,710	$907.57	$987.84
Gulf	Maternity Kick Payment	Maternity Kick Payment	10,987	$8,693.19	$8,930.22
Gulf	EED Kick Payment	EED Kick Payment	N/A	$4,989.91	$5,071.30
Capital	SSI	0-2 Months	168	$29,990.86	$31,463.67
Capital	SSI	3-11 Months	1,491	$5,427.68	$5,721.44
Capital	SSI	Child 1-18	89,519	$428.69	$457.43
Capital	SSI	Adult 19+	210,439	$1,041.06	$1,100.97
Capital	Family & Children	0-2 Months	38,789	$1,860.57	$1,949.19
Capital	Family & Children	3-11 Months	94,611	$267.11	$286.00
Capital	Family & Children	Child 1-18	1,863,396	$126.75	$135.38
Capital	Family & Children	Adult 19+	268,984	$369.43	$390.13
Capital	BCC	BCC, All Ages	3,946	$2,174.10	$2,303.74
Capital	LAP	LAP, All Ages	10,487	$155.77	$166.24
Capital	HCBS	Child 0-18	7,164	$1,540.61	$1,669.94

Region Description	COA Description	Rate Cell Description	CY13 MMs or Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
Capital	HCBS	Adult 19+	21,638	$601.27	$646.55
Capital	CCM	CCM, All Ages	15,831	$908.48	$988.75
Capital	Maternity Kick Payment	Maternity Kick Payment	9,772	$8,042.15	$8,252.09
Capital	EED Kick Payment	EED Kick Payment	N/A	$5,209.55	$5,300.45
South Central	SSI	0-2 Months	217	$29,299.51	$30,772.32
South Central	SSI	3-11 Months	1,692	$5,341.06	$5,634.83
South Central	SSI	Child 1-18	91,728	$447.09	$474.60
South Central	SSI	Adult 19+	247,354	$960.19	$1,013.28
South Central	Family & Children	0-2 Months	43,502	$2,067.98	$2,162.65
South Central	Family & Children	3-11 Months	104,512	$285.49	$303.81
South Central	Family & Children	Child 1-18	2,038,315	$134.79	$143.67
South Central	Family & Children	Adult 19+	285,454	$339.25	$358.20
South Central	BCC	BCC, All Ages	2,893	$2,188.81	$2,318.46
South Central	LAP	LAP, All Ages	12,222	$156.56	$167.04
South Central	HCBS	Child 0-18	6,665	$1,543.77	$1,673.11
South Central	HCBS	Adult 19+	23,110	$604.14	$649.42
South Central	CCM	CCM, All Ages	16,556	$907.77	$988.04
South Central	Maternity Kick Payment	Maternity Kick Payment	10,504	$7,621.88	$7,830.28
South Central	EED Kick Payment	EED Kick Payment	N/A	$4,707.02	$4,792.92
North	SSI	0-2 Months	239	$29,599.93	$31,072.74
North	SSI	3-11 Months	1,678	$5,356.16	$5,649.93
North	SSI	Child 1-18	100,260	$407.65	$431.58
North	SSI	Adult 19+	212,259	$921.58	$971.65
North	Family & Children	0-2 Months	32,253	$1,974.38	$2,071.47
North	Family & Children	3-11 Months	80,214	$262.78	$280.30
North	Family & Children	Child 1-18	1,587,962	$121.17	$128.96
North	Family & Children	Adult 19+	213,631	$324.52	$342.79
North	BCC	BCC, All Ages	2,395	$2,203.79	$2,333.44

Region Description	COA Description	Rate Cell Description	CY13 MMs or Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
North	LAP	LAP, All Ages	6,545	$156.57	$167.05
North	HCBS	Child 0-18	4,164	$1,544.93	$1,674.26
North	HCBS	Adult 19+	17,320	$605.27	$650.55
North	CCM	CCM, All Ages	16,472	$908.28	$988.54
North	Maternity Kick Payment	Maternity Kick Payment	8,132	$7,733.60	$7,947.96
North	EED Kick Payment	EED Kick Payment	N/A	$4,568.79	$4,650.14

Appendix B: Bayou Health Eligibility Designation

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
SSI (Aged, Blind and Disabled)				
Acute Care Hospitals (LOS > 30 days)	●			
BPL (Walker vs. Bayer)	●			
Disability Medicaid	●			
Disabled Adult Child	●			
Disabled Widow/Widower (DW/W)	●			
Early Widow/Widowers	●			
Family Opportunity Program*	●		●	
Former SSI*	●		●	
Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	●			
PICKLE	●			
Provisional Medicaid	●			
Section 4913 Children	●			
SGA Disabled W/W/DS	●			
SSI (Supplemental Security Income)*	●		●	
SSI Conversion	●			
Tuberculosis (TB)	●			
SSI (OCS Foster Care, IV-E OCS/OYD and OCS/OYD (XIX))				
Foster Care IV-E - Suspended SSI			●	
SSI (Supplemental Security Income)			●	
TANF (Families and Children, LIFC)				
CHAMP Child	●			
CHAMP Pregnant Woman (to 133% of FPIG)	●			
CHAMP Pregnant Woman Expansion (to 185%	●			

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
FPIG)				
Deemed Eligible	●			
ELE - Food Stamps (Express Lane Eligibility-Food Stamps)	●			
Grant Review	●			
LaCHIP Phase 1	●			
LaCHIP Phase 2	●			
LaCHIP Phase 3	●			
LaCHIP Phase IV: Non-Citizen Pregnant Women Expansion	●			
LIFC - Unemployed Parent / CHAMP	●			
LIFC Basic	●			
PAP - Prohibited AFDC Provisions	●			
Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL	●			
Regular MNP (Medically Needy Program)	●			
Transitional Medicaid	●			
FCC (Families and Children)				
Former Foster Care children	●			
Youth Aging Out of Foster Care (Chaffee Option)	●			
FCC (OCS Foster Care, IV-E OCS/OYD and OCS/OYD (XIX))				
CHAMP Child			●	
CHAMP Pregnant Woman (to 133% of FPIG)			●	
IV-E Foster Care			●	
LaCHIP Phase 1			●	
OYD - V Category Child			●	
Regular Foster Care Child			●	

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
YAP (Young Adult Program)			●	
YAP/OYD			●	
BCC (Families and Children)				
Breast and/or Cervical Cancer	●			
LAP (Families and Children)				
LaCHIP Affordable Plan	●			
HCBS Waiver				
ADHC (Adult Day Health Services Waiver)		●		
Children's Waiver - Louisiana Children's Choice		●		
Community Choice Waiver		●		
New Opportunities Waiver - SSI		●		
New Opportunities Waiver Fund		●		
New Opportunities Waiver, non-SSI		●		
Residential Options Waiver - non-SSI		●		
Residential Options Waiver - SSI		●		
SSI Children's Waiver - Louisiana Children's Choice		●		
SSI Community Choice Waiver		●		
SSI New Opportunities Waiver Fund		●		
SSI/ADHC		●		
Supports Waiver		●		
Supports Waiver SSI		●		
CCM				
Chisholm Class Members**		●		
LaHIPP				
Louisiana's Health Insurance Premium Payment Program***	●	●	●	●

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
Excluded				
CHAMP Presumptive Eligibility				●
CSOC				●
DD Waiver				●
Denied SSI Prior Period				●
Disabled Adults authorized for special hurricane Katrina assistance				●
EDA Waiver				●
Family Planning, New eligibility / Non-LaMOM				●
Family Planning, Previous LaMOMs eligibility				●
Family Planning/Take Charge Transition				●
Forced Benefits				●
GNOCHC Adult Parent				●
GNOCHC Childless Adult				●
HPE B/CC				●
HPE Children under age 19				●
HPE Family Planning				●
HPE Former Foster Care				●
HPE LaCHIP				●
HPE LaCHIP Unborn				●
HPE Parent/Caretaker Relative				●
HPE Pregnant Woman				●
LBHP - Adult 1915(i)				●
LTC (Long-Term Care)				●
LTC Co-Insurance				●
LTC MNP/Transfer of Resources				●

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
LTC Payment Denial/Late Admission Packet				●
LTC Spend-Down MNP				●
LTC Spend-Down MNP (Income > Facility Fee)				●
OCS Child Under Age 18 (State Funded)				●
OYD (Office of Youth Development)				●
PACE SSI				●
PACE SSI-related				●
PCA Waiver				●
Private ICF/DD				●
Private ICF/DD Spend-Down Medically Needy Program				●
Private ICF/DD Spend-Down Medically Needy Program/Income Over Facility Fee				●
Public ICF/DD				●
Public ICF/DD Spend-Down Medically Needy Program				●
QI-1 (Qualified Individual - 1)				●
QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)				●
QMB (Qualified Medicare Beneficiary)				●
SLMB (Specified Low-Income Medicare Beneficiary)				●
Spend-Down Medically Needy Program				●
Spend-Down Denial of Payment/Late Packet				●
SSI Conversion / Refugee Cash Assistance (RCA)/ LIFC Basic				●
SSI DD Waiver				●
SSI Payment Denial/Late Admission				●
SSI PCA Waiver				●

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
SSI Transfer of Resource(s)/LTC				●
SSI/EDA Waiver				●
SSI/LTC				●
SSI/Private ICF/DD				●
SSI/Public ICF/DD				●
State Retirees				●
Terminated SSI Prior Period				●
Transfer of Resource(s)/LTC				●

* Children under 19 years of age who are automatically enrolled into Bayou Health, but may voluntarily disenroll.
** Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the OCDD's Request for Services Registry who are *CCMs*.
*** LaHIPP is not a category of eligibility. Eligibility designation for LaHIPP enrollees will vary according to the qualifying category of eligibility.

Appendix C: Bayou Health Covered Services

Medicaid Category of Service	Units of Measurement	Completion Category of Service
Inpatient Hospital	Days	Inpatient
Outpatient Hospital	Claims	Outpatient
Primary Care Physician	Visits	Physician
Specialty Care Physician	Visits	Physician
FQHC/RHC	Visits	Physician
EPSDT	Visits	Physician
Certified Nurse Practitioners/Clinical Nurse	Claims	Physician
Lab/Radiology	Units	Other
Home Health	Visits	Other
Emergency Transportation	Units	Transportation
NEMT	Units	Transportation
Rehabilitation Services (occupational therapy {OT}, physical therapy {PT}, speech therapy {ST})	Visits	Other
DME	Units	Other
Clinic	Claims	Physician
Family Planning	Visits	Physician
Other*	Units	Other
Prescribed Drugs	Scripts	Prescribed Drugs
ER	Visits	Outpatient
Basic Behavioral Health	Claims	Physician
Hospice*	Admits	Inpatient
Personal Care Services (Age 0-20)*	Units	Physician

* Services that were previously excluded from the Bayou Health program and now are included.

Appendix D: NEMT Adjustment

		NEMT Adjustment				
COA Description	**Rate Cell Description**	**Gulf (%)**	**Capital (%)**	**Southwest (%)**	**North (%)**	**Total (%)**
SSI	Newborns, 0-2 Months of Age	0.0	0.0	0.0	0.0	0.0
SSI	Newborns, 3-11 Months of Age	0.0	0.0	0.0	0.0	0.0
SSI	Child, 1-18 Years of Age	183.3	73.1	42.9	9.7	68.7
SSI	Adult, 19+ Years of Age	24.1	25.9	14.5	12.6	20.0
Family & Children	Newborns, 0-2 Months of Age	0.0	0.9	1.0	0.3	0.3
Family & Children	Newborns, 3-11 Months of Age	0.0	0.1	0.1	0.8	0.2
Family & Children	Child, 1-18 Years of Age	73.2	49.9	26.1	13.9	39.7
Family & Children	Adult, 19+ Years of Age	12.1	13.8	6.6	2.4	9.4
BCC	BCC, All Ages	0.0	1.1	1.5	2.5	1.1
LAP	LAP, All Ages	13.4	34.2	0.0	0.0	7.8
HCBS	Child, 0-18 Years of Age	0.0	0.0	0.0	0.0	0.0
HCBS	Adult, 19+ Years of Age	0.0	0.0	0.0	0.0	0.0
CCM	CCM, All Ages	0.0	0.0	0.0	0.0	0.0
Maternity Kick Payment	Maternity Kick Payment	0.0	0.0	0.0	0.0	0.0
Total		**27.4**	**27.7**	**14.8**	**10.3**	**20.9**

Appendix E: Behavioral Health Mixed Services Protocol

PMPM Impact of Behavioral Health Mixed Services Protocol							
COA Description	**Rate Cell Description**	**Inpatient Hospital (%)**	**Outpatient Hospital (%)**	**Primary Care Physician (%)**	**ER (%)**	**FQHC/RHC (%)**	**Total (%)**
SSI	Newborns, 0-2 Months of Age	0.0	0.0	0.0	0.0	0.0	0.0
SSI	Newborns, 3-11 Months of Age	0.0	0.0	0.0	0.0	0.1	0.0
SSI	Child, 1-18 Years of Age	1.1	0.3	4.4	4.8	10.4	2.4
SSI	Adult, 19+ Years of Age	0.6	0.1	1.0	5.0	0.9	1.3
Family & Children	Newborns, 0-2 Months of Age	0.0	0.0	0.0	0.0	0.0	0.0
Family & Children	Newborns, 3-11 Months of Age	0.0	0.0	0.0	0.0	0.0	0.0
Family & Children	Child, 1-18 Years of Age	1.6	0.1	1.2	1.5	3.7	1.5
Family & Children	Adult, 19+ Years of Age	0.6	0.1	0.7	1.9	1.0	1.0
BCC	BCC, All Ages	0.0	0.0	0.1	1.1	0.3	0.1
LAP	LAP, All Ages	1.1	0.0	1.4	1.3	5.5	1.4
HCBS	Child, 0-18 Years of Age	0.4	0.1	2.6	6.4	13.4	1.4
HCBS	Adult, 19+ Years of Age	0.4	0.1	1.3	9.2	3.4	1.5
CCM	CCM, All Ages	1.5	0.3	4.0	4.3	9.4	2.3
Total		**0.5**	**0.1**	**1.0**	**2.5**	**2.8**	**1.1**

Appendix F-1: Shared Savings/FFS IBNR Adjustment

	COA Description						
Category of Service Description	**SSI**	**Family & Children**	**BCC**	**LAP**	**HCBS**	**CCM**	**Maternity Kick Payment**
	(%)	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**
Inpatient Hospital	4.6	6.1	4.6	6.1	2.6	4.6	N/A
Outpatient Hospital	2.9	2.6	2.9	2.6	2.4	2.9	N/A
Primary Care Physician	3.8	2.4	3.8	2.4	3.9	3.8	N/A
Specialty Care Physician	3.8	2.4	3.8	2.4	3.9	3.8	N/A
FQHC/RHC	3.8	2.4	3.8	2.4	3.9	3.8	N/A
EPSDT	3.8	2.5	0.0	2.4	3.9	3.8	N/A
Certified Nurse Practitioners/Clinical Nurse	3.8	2.4	3.8	2.4	3.9	3.8	N/A
Lab/Radiology	3.3	3.0	3.3	3.0	1.5	3.3	N/A
Home Health	3.3	3.0	3.3	3.0	1.5	3.3	N/A
Emergency Transportation	2.4	3.8	2.4	3.8	1.3	2.4	N/A
NEMT	2.4	3.8	2.4	3.8	1.3	2.4	N/A
Rehabilitation Services (OT, PT, ST)	3.3	3.0	0.0	3.0	1.5	3.3	N/A
DME	3.3	3.0	3.3	3.0	1.5	3.3	N/A
Clinic	3.8	2.5	3.8	2.4	3.9	3.8	N/A
Family Planning	3.8	2.4	3.8	2.4	3.9	3.8	N/A
Other	3.3	3.0	3.3	3.0	1.5	3.3	N/A
Prescribed Drugs	0.0	0.0	0.0	0.0	0.0	0.0	N/A
ER	2.9	2.6	2.9	2.6	2.4	2.9	N/A
Basic Behavioral Health	3.8	2.5	3.8	2.4	3.9	3.8	N/A
Hospice	4.6	6.1	4.6	0.0	2.6	4.6	N/A
Personal Care Services	3.8	2.6	0.0	0.0	3.9	3.8	N/A
Total	**2.2**	**2.3**	**2.4**	**1.7**	**1.6**	**2.6**	**4.0**

Appendix F-2: Prepaid IBNR Adjustment

	COA Description						
Category of Service Description	**SSI**	**Family & Children**	**BCC**	**LAP**	**HCBS**	**CCM**	**Maternity Kick Payment**
	(%)	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**
Inpatient Hospital	2.0	6.9	1.7	9.7	N/A	N/A	N/A
Outpatient Hospital	2.4	3.0	2.6	2.6	N/A	N/A	N/A
Primary Care Physician	2.8	3.0	2.8	3.0	N/A	N/A	N/A
Specialty Care Physician	2.8	3.0	2.8	3.0	N/A	N/A	N/A
FQHC/RHC	2.9	3.0	2.9	3.0	N/A	N/A	N/A
EPSDT	2.9	3.0	2.4	3.0	N/A	N/A	N/A
Certified Nurse Practitioners/Clinical Nurse	2.8	3.0	2.8	3.1	N/A	N/A	N/A
Lab/Radiology	1.1	0.0	1.3	0.0	N/A	N/A	N/A
Home Health	1.1	0.0	1.3	0.0	N/A	N/A	N/A
Emergency Transportation	3.1	2.3	3.1	2.3	N/A	N/A	N/A
NEMT	1.3	1.5	1.6	2.4	N/A	N/A	N/A
Rehabilitation Services (OT, PT, ST)	1.1	0.0	0.5	0.0	N/A	N/A	N/A
DME	1.0	0.0	1.1	0.0	N/A	N/A	N/A
Clinic	2.5	3.1	2.7	2.9	N/A	N/A	N/A
Family Planning	2.8	3.0	2.8	2.8	N/A	N/A	N/A
Other	1.3	0.0	1.5	0.0	N/A	N/A	N/A
Prescribed Drugs	0.0	0.0	0.0	0.0	N/A	N/A	N/A
ER	2.3	2.9	2.4	2.6	N/A	N/A	N/A
Basic Behavioral Health	2.9	3.0	2.8	3.0	N/A	N/A	N/A
Hospice	4.6	6.1	4.6	0.0	N/A	N/A	N/A
Personal Care Services	3.8	2.4	0.0	0.0	N/A	N/A	N/A
Total	**1.4**	**2.9**	**1.9**	**2.2**	**N/A**	**N/A**	**2.1**

Appendix G-1: ACA PCP Carve-Out Adjustment – Shared Savings/FFS Claims

COA Description	MMs	Expenses	PMPM	ACA Enhanced Claims	ACA Carve-Out	Enhanced Claims at Medicaid Fee Schedule	ACA Carve-Out PMPM
SSI	534,039	$335,720,231	$628.64	$16,912,081	$ (4,741,489)	$12,170,592	$(8.88)
Family & Children	4,803,890	$687,008,562	$143.01	$119,227,890	$ (31,854,474)	$87,373,415	$(6.63)
BCC	3,894	$5,411,598	$1,389.73	$125,195	$ (36,099)	$89,096	$(9.27)
LAP	24,552	$3,089,875	$125.85	$580,909	$ (159,439)	$421,470	$(6.49)
HCBS	104,050	$74,126,785	$712.42	$1,792,858	$ (546,701)	$1,246,156	$(5.25)
CCM	63,548	$49,066,793	$772.12	$1,830,936	$ (438,595)	$1,392,341	$(6.90)
Maternity Kick Payment	20,227	$93,991,004	$4,646.74	$118,341	$(34,420)	$83,921	$(1.70)
Total	**5,533,973**	**$1,248,414,847**	**$225.59**	**$140,588,209.72**	**$ (37,811,217.78)**	**$102,776,991.94**	**$(6.83)**

Appendix G-2: ACA PCP Carve-Out Adjustment – Prepaid Encounter Claims

COA Description	MMs	Expenses	PMPM	ACA Enhanced Claims	ACA Carve-Out	Enhanced Claims at Medicaid Fee Schedule	ACA Carve-Out PMPM
SSI	817,967	$484,281,922	$592.06	$22,217,143	$(6,355,861)	$15,861,282	$(7.77)
Family & Children	4,406,937	$554,415,102	$125.81	$86,893,087	$(22,109,241)	$64,783,846	$(5.02)
BCC	9,032	$11,294,648	$1,250.51	$277,935	$(75,376)	$202,560	$(8.35)
LAP	14,159	$1,560,869	$110.24	$260,918	$(70,249)	$190,668	$(4.96)
HCBS	-	$-	$-	$-	$-	$-	$-
CCM	-	$-	$-	$-	$-	$-	$-
Maternity Kick Payment	19,132	$89,550,169	$4,680.59	$122,458	$(33,773)	$88,685	$(1.76)
Total	**5,248,095**	**$1,141,102,710**	**$217.43**	**$109,771,540.72**	**$(28,644,499.92)**	**$81,127,040.80**	**$(5.46)**

Appendix H-1: 6-Month Average Duration Calculation

	SSI			Family & Children[4]			BCC[4]		
First Month of Enrollment	**Recipients**	**Member Months**	**Average Duration**	**Recipients**	**Member Months**	**Average Duration**	**Recipients**	**Member Months**	**Average Duration**
Jul-13	1,022	2,073	2.0	5,109	8,174	1.6	24	47	2.0
Aug-13	1,129	2,292	2.0	6,475	10,519	1.6	29	55	1.9
Sept-13	1,178	2,399	2.0	6,123	9,436	1.5	31	57	1.8
Oct-13	1,022	2,219	2.2	5,678	9,096	1.6	15	29	1.9
Nov-13	1,196	2,369	2.0	5,697	10,118	1.8	35	70	2.0
Dec-13	1,089	2,220	2.0	4,720	7,916	1.7	19	37	1.9
6-Month Avg. Duration			**2.0**			**1.6**			**1.9**

[4] Revised due to a typographical error in the certification letter dated January 31, 2015.

Appendix H-2: Statewide Summary by Rating Category

		Retro-Active Period Claims						Total Base Claims			Total Base Claims Including Retro-Active Adjustment				
		(A)	(B)	(C)	(D)	(E) = (C)/(B)	(F) = (A)*(D)*(E)	(G)	(H)	(I) = (H)/(G)	(J) = (A)*(D)+(G)	(K) = (F)+(H)	(L) = (K)/(J)	(M) = (L)/(I)	(N) = MAX(L,1)
Category of Aid	Category of Aid Description	Recipients	Member Months (Capped at 12 months)	Claims	Selected Avg. Duration	Claims PMPM	Modified Claims Total	Member Months	Claims	Claims PMPM	Member Months	Claims	Claims PMPM	Observed Retro Factor	Final Retro Factor
SSI	Newborn, 0-2 Months	-	-	$ -	2.05	$ -	$ -	915	$ 17,215,170	$ 18,814	915	$ 17,215,170	$ 18,814	1.0000	1.0000
SSI	Newborn, 3-11 Months	-	-	$ -	2.05	$ -	$ -	6,651	$ 24,818,296	$ 3,732	6,651	$ 24,818,296	$ 3,732	1.0000	1.0000
SSI	Child, 1-18 Years	1,097	3,528	$ 779,022	2.05	$ 220.81	$ 495,801	403,901	$ 123,004,730	$ 305	406,146	$ 123,500,531	$ 304	0.9985	1.0000
SSI	Adult, 19+ Years	12,278	32,453	$ 26,548,934	2.05	$ 818.07	$ 20,558,886	946,756	$ 639,085,266	$ 675	971,887	$ 659,644,152	$ 679	1.0055	1.0055
Family and Children	Newborn, 0-2 Months	-	-	$ -	1.63	$ -	$ -	157,724	$ 179,711,511	$ 1,139	157,724	$ 179,711,511	$ 1,139	1.0000	1.0000
Family and Children	Newborn, 3-11 Months	-	-	$ -	1.63	$ -	$ -	383,886	$ 79,427,903	$ 207	383,886	$ 79,427,903	$ 207	1.0000	1.0000
Family and Children	Child, 1-18 Years	30,101	73,414	$ 4,988,780	1.63	$ 67.95	$ 3,332,762	7,542,938	$ 696,145,300	$ 92	7,591,982	$ 699,478,063	$ 92	0.9983	1.0000
Family and Children	Adult, 19+ Years	42,338	64,174	$ 18,628,437	1.63	$ 290.28	$ 20,024,218	1,142,074	$ 255,222,939	$ 223	1,211,056	$ 275,247,157	$ 227	1.0170	1.0170
Breast and Cervical Cancer	BCC, All Ages Female	366	822	$ 2,540,941	1.93	$ 3,091.17	$ 2,183,263	12,936	$ 16,384,789	$ 1,267	13,642	$ 18,568,052	$ 1,361	1.0746	1.0746
LaCHIP Affordable Plan	All Ages	-	-	$ -	-	$ -	$ -	38,711	$ 4,566,649	$ 118	38,711	$ 4,566,649	$ 118	1.0000	1.0000
HCBS Waiver	18 & Under, Male and Female	-	-	$ -	-	$ -	$ -	24,819	$ 32,738,606	$ 1,319	24,819	$ 32,738,606	$ 1,319	1.0000	1.0000
HCBS Waiver	19+ Years, Male and Female	-	-	$ -	-	$ -	$ -	83,364	$ 41,966,487	$ 503	83,364	$ 41,966,487	$ 503	1.0000	1.0000
Chisholm Class Members	Chisholm, All Ages Male & Female	-	-	$ -	-	$ -	$ -	64,569	$ 47,801,497	$ 740	64,569	$ 47,801,497	$ 740	1.0000	1.0000
Maternity Kickpayment	Maternity Kickpayment, All Ages	-	-	$ -	-	$ -	$ -	37,572	$ 178,244,133	$ 4,744	37,572	$ 178,244,133	$ 4,744	1.0000	1.0000

Notes:

* The above analysis does not include payments to members who paid out-of-pocket for services before being enrolled in Medicaid.

1. Final retro-adjustment factor was set to a 1.0 factor for those instances where the observed retro-active factor resulted in a negative adjustment.
2. Retro-active period claims not credible as the LAP population entered into Bayou Health effective January 1, 2013. Assumes Family & Children experience for the LAP retro-adjustment factor.
3. HCBS waiver and Chisholm populations are new to the Bayou Health program and no retro-active claims experience is available to determine retro-active period adjustment factor.

Appendix I-1: Annualized Trend Adjustment for SSI/BCC

	Annualized Trend					
	SSI/BCC					
Category of Service Description	**Low Util (%)**	**High Util (%)**	**Low Unit Cost (%)**	**High Unit Cost (%)**	**Low PMPM (%)**	**High PMPM (%)**
Inpatient Hospital	0.0	2.0	0.0	1.0	0.0	3.0
Outpatient Hospital	1.0	4.0	1.0	3.0	2.0	7.1
Primary Care Physician	1.0	5.0	1.0	2.0	2.0	7.1
Specialty Care Physician	1.0	5.0	1.0	2.0	2.0	7.1
FQHC/RHC	2.0	5.0	1.0	2.0	3.0	7.1
EPSDT	1.0	5.0	1.0	2.0	2.0	7.1
Certified Nurse Practitioners/Clinical Nurse	1.0	5.0	1.0	2.0	2.0	7.1
Lab/Radiology	1.0	2.0	1.0	2.0	2.0	4.0
Home Health	1.0	2.0	1.0	2.0	2.0	4.0
Emergency Transportation	1.0	2.0	1.0	2.0	2.0	4.0
NEMT	1.0	2.0	1.0	2.0	2.0	4.0
Rehabilitation Services (OT, PT, ST)	1.0	2.0	1.0	2.0	2.0	4.0
DME	1.0	2.0	1.0	2.0	2.0	4.0
Clinic	1.0	5.0	1.0	2.0	2.0	7.1
Family Planning	1.0	5.0	1.0	2.0	2.0	7.1
Other	1.0	2.0	1.0	2.0	2.0	4.0
Prescribed Drugs	5.4	7.2	0.0	0.0	5.4	7.2
ER	0.0	1.0	1.0	3.0	1.0	4.0
Basic Behavioral Health	1.0	5.0	1.0	2.0	2.0	7.1
Hospice	1.0	2.0	1.0	2.0	2.0	4.0
Personal Care Services	1.0	2.0	1.0	2.0	2.0	4.0
Total	**2.4**	**4.6**	**0.4**	**1.2**	**2.8**	**5.8**

Appendix I-2: Annualized Trend Adjustment for Family & Children/LAP

	Annualized Trend					
	Family & Children/LAP					
Category of Service Description	**Low Util (%)**	**High Util (%)**	**Low Unit Cost (%)**	**High Unit Cost (%)**	**Low PMPM (%)**	**High PMPM (%)**
Inpatient Hospital	0.0	2.0	0.0	1.0	0.0	3.0
Outpatient Hospital	2.0	5.0	1.0	3.0	3.0	8.2
Primary Care Physician	1.0	5.0	1.0	2.0	2.0	7.1
Specialty Care Physician	1.0	5.0	1.0	2.0	2.0	7.1
FQHC/RHC	2.0	5.0	1.0	2.0	3.0	7.1
EPSDT	1.0	5.0	1.0	2.0	2.0	7.1
Certified Nurse Practitioners/Clinical Nurse	1.0	5.0	1.0	2.0	2.0	7.1
Lab/Radiology	1.0	2.0	1.0	2.0	2.0	4.0
Home Health	1.0	2.0	1.0	2.0	2.0	4.0
Emergency Transportation	1.0	2.0	1.0	2.0	2.0	4.0
NEMT	1.0	2.0	1.0	2.0	2.0	4.0
Rehabilitation Services (OT, PT, ST)	1.0	2.0	1.0	2.0	2.0	4.0
DME	1.0	2.0	1.0	2.0	2.0	4.0
Clinic	1.0	5.0	1.0	2.0	2.0	7.1
Family Planning	1.0	5.0	1.0	2.0	2.0	7.1
Other	1.0	2.0	1.0	2.0	2.0	4.0
Prescribed Drugs	5.4	7.2	0.0	0.0	5.4	7.2
ER	0.0	1.0	1.0	2.0	1.0	3.0
Basic Behavioral Health	1.0	5.0	1.0	2.0	2.0	7.1
Hospice	1.0	2.0	1.0	2.0	2.0	4.0
Personal Care Services	1.0	2.0	1.0	2.0	2.0	4.0
Total	**2.1**	**4.5**	**0.5**	**1.3**	**2.7**	**5.8**

Appendix I-3: Annualized Trend Adjustment for HCBS Waiver/CCMs

	HCBS Waiver/Chisholm Class Members					
Category of Service Description	**Low Util (%)**	**High Util (%)**	**Low Unit Cost (%)**	**High Unit Cost (%)**	**Low PMPM (%)**	**High PMPM (%)**
Inpatient Hospital	0.0	2.0	1.0	1.0	1.0	3.0
Outpatient Hospital	1.5	4.5	2.0	4.0	3.5	8.7
Primary Care Physician	1.0	5.0	1.0	1.0	2.0	6.1
Specialty Care Physician	1.0	5.0	1.0	1.0	2.0	6.1
FQHC/RHC	1.0	5.0	2.0	2.0	3.0	7.1
EPSDT	1.0	5.0	1.0	1.0	2.0	6.1
Certified Nurse Practitioners/Clinical Nurse	1.0	5.0	1.0	1.0	2.0	6.1
Lab/Radiology	1.0	3.0	1.0	1.0	2.0	4.0
Home Health	1.0	3.0	1.0	1.0	2.0	4.0
Emergency Transportation	0.0	3.0	1.0	1.0	1.0	4.0
NEMT	0.0	3.0	1.0	1.0	1.0	4.0
Rehabilitation Services (OT, PT, ST)	1.0	3.0	1.0	1.0	2.0	4.0
DME	1.0	3.0	1.0	1.0	2.0	4.0
Clinic	1.0	5.0	1.0	1.0	2.0	6.1
Family Planning	1.0	5.0	1.0	1.0	2.0	6.1
Other	1.0	3.0	1.0	1.0	2.0	4.0
Prescribed Drugs	1.0	2.0	1.0	1.0	2.0	3.0
ER	1.5	4.5	2.0	4.0	3.5	8.7
Basic Behavioral Health	1.0	5.0	1.0	1.0	2.0	6.1
Hospice	1.0	3.0	1.0	1.0	2.0	4.0
Personal Care Services	1.0	5.0	1.0	1.0	2.0	6.1
Total	**0.9**	**3.2**	**1.1**	**1.2**	**2.0**	**4.5**

Appendix J-1: Managed Care Savings Adjustment – HCBS Waiver/CCM

	Managed Care Savings Assumptions					
	HCBS Waiver/CCM[5],[6]					
Category of Service Description	**Low Util (%)**	**High Util (%)**	**Low Unit Cost (%)**	**High Unit Cost (%)**	**Low PMPM (%)**	**High PMPM (%)**
Inpatient Hospital	-12.5	-10.0	1.0	5.0	-11.6	-5.5
Outpatient Hospital	-10.0	-7.5	1.0	3.0	-9.1	-4.7
Primary Care Physician	2.5	5.0	5.0	7.0	7.6	12.4
Specialty Care Physician	-12.5	-10.0	0.0	2.0	-12.5	-8.2
FQHC/RHC	0.0	2.5	0.0	2.0	0.0	4.5
EPSDT	0.0	0.0	5.0	7.0	5.0	7.0
Certified Nurse Practitioners/Clinical Nurse	2.5	5.0	5.0	7.0	7.6	12.4
Lab/Radiology	-10.0	-5.0	0.0	2.0	-10.0	-3.1
Home Health	0.0	0.0	0.0	2.0	0.0	2.0
Emergency Transportation	-5.0	-2.5	0.0	2.0	-5.0	-0.6
NEMT	0.0	2.5	0.0	2.0	0.0	4.5
Rehabilitation Services (OT, PT, ST)	-5.0	-2.5	0.0	2.0	-5.0	-0.6
DME	-10.0	-7.5	0.0	2.0	-10.0	-5.6
Clinic	-10.0	-7.5	0.0	2.0	-10.0	-5.6
Family Planning	0.0	2.5	0.0	2.0	0.0	4.5
Other	0.0	2.5	0.0	2.0	0.0	4.5
Prescribed Drugs	-10.4	-10.4	0.0	0.0	-10.4	-10.4
ER	-12.5	-10.0	5.0	7.0	-8.1	-3.7
Basic Behavioral Health	0.0	0.0	0.0	2.0	0.0	2.0
Hospice	0.0	0.0	0.0	0.0	0.0	0.0
Personal Care Services	-10.0	-5.0	0.0	0.0	-10.0	-5.0
Total	**-7.2**	**-5.9**	**0.9**	**2.2**	**-6.4**	**-3.7**

[5] The HCBS waiver and CCM population are previously unmanaged populations.

[6] Current services for Prepaid, Shared Savings, and LaHIPP populations are managed and Managed Care savings are not applied

Appendix J-2: Managed Care Savings Adjustment – Shared Savings

	Managed Care Savings Assumptions					
	Shared Savings*					
Category of Service Description	**Low Util (%)**	**High Util (%)**	**Low Unit Cost (%)**	**High Unit Cost (%)**	**Low PMPM (%)**	**High PMPM (%)**
Inpatient Hospital						
Outpatient Hospital						
Primary Care Physician						
Specialty Care Physician						
FQHC/RHC						
EPSDT						
Certified Nurse Practitioners/Clinical Nurse						
Lab/Radiology						
Home Health						
Emergency Transportation						
NEMT	0.0	5.0	0.0	2.0	0.0	7.1
Rehabilitation Services (OT, PT, ST)						
DME	-0.2	-15.0	0.0	2.0	-0.2	-13.3
Clinic						
Family Planning						
Other						
Prescribed Drugs	-1.0**	-0.5**	0.0	0.0	-1.0**	-0.5**
ER						
Basic Behavioral Health						
Hospice	0.0	0.0	0.0	0.0	0.0	0.0
Personal Care Services	-10.0	-5.0	0.0	0.0	-10.0	-5.0
Total	**-0.5**	**-0.2**	**0.0**	**0.0**	**-0.5**	**-0.2**

* Covered services previously not covered under the Shared Savings program.

** These Shared Savings managed care savings assumptions are not applied to the BCC COA.

*** Current services for Prepaid, Shared Savings, and LaHIPP populations are managed and Managed Care savings are not applied.

Appendix K: Non-Medical Expense Load

Retention Loads by Rate Cell									
		Lower Bound of Range				Upper Bound of Range			
		Gulf	Capital	South Central	North	Gulf	Capital	South Central	North
COA Description	Rate Cell Description	Retention %	Retention %	Retention %	Retention %	Retention %	Retention %	Retention %	Retention %
SSI	Newborns, 0-2 Months of Age	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7
SSI	Newborns, 3-11 Months of Age	9.5	9.5	9.5	9.5	9.5	9.5	9.5	9.5
SSI	Child, 1-18 Years of Age	11.4	10.9	10.5	11.2	11.4	10.9	10.6	11.2
SSI	Adult, 19+ Years of Age	9.5	9.4	9.6	9.8	9.6	9.4	9.6	9.8
Family & Children	Newborns, 0-2 Months of Age	10.5	10.5	10.4	10.4	10.5	10.4	10.4	10.4
Family & Children	Newborns, 3-11 Months of Age	14.0	13.4	13.3	13.6	13.9	13.4	13.3	13.5
Family & Children	Child, 1-18 Years of Age	18.4	17.5	17.0	18.3	18.4	17.5	17.0	18.3
Family & Children	Adult, 19+ Years of Age	12.7	12.0	12.4	12.7	12.7	12.0	12.4	12.7
BCC	BCC, All Ages	9.6	9.6	9.6	9.6	9.6	9.6	9.6	9.6
LAP	LAP, All Ages	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0
HCBS	Child, 0-18 Years of Age	9.8	9.8	9.8	9.8	9.8	9.8	9.8	9.8
HCBS	Adult, 19+ Years of Age	10.1	10.1	10.1	10.1	10.2	10.2	10.2	10.2

Retention Loads by Rate Cell									
		Lower Bound of Range				Upper Bound of Range			
		Gulf	Capital	South Central	North	Gulf	Capital	South Central	North
COA Description	Rate Cell Description	Retention %	Retention %	Retention %	Retention %	Retention %	Retention %	Retention %	Retention %
CCM	CCM, All Ages	10.1	10.1	10.1	10.1	10.1	10.1	10.1	10.1
Maternity Kick Payment	Maternity Kick Payment	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7

Appendix L: Data Reliance Attestation

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

August 27, 2014

Mr. Jaredd Simons, ASA, MAAA
Senior Associate
Mercer Government Human Services
3560 Lenox Road, Suite 2400
Atlanta, GA 30326

Subject: Capitation Rate Range Certification for the Bayou Health Prepaid Program – Implementation Year (February 1, 2015 – January 31, 2016)

Dear Jaredd:

I, Jen Steele, Medicaid Deputy Director and Chief Financial Officer, for the State of Louisiana's Department of Health and Hospitals (DHH), hereby affirm that the data prepared and submitted to Mercer Government Human Services Consulting (Mercer) for the purpose of certifying the February 1, 2015 – January 31, 2016 Prepaid rates were prepared under my direction, and to the best of my knowledge and belief, are accurate, complete, and consistent with the data used to develop the capitation rates. This data includes calendar year (CY) 2013 fee-for-service (FFS) data files, MCO submitted encounter data, and supplemental information on payments made outside of Louisiana's Medicaid Management Information Systems (MMIS).

Mercer relied on DHH and its fiscal agent for the collection and processing of the FFS data, encounter data, and other information used in setting these capitation rates. Mercer did not audit the data, but did assess the data for reasonableness as documented in the rate certification letter.

Jen Steele
Signature

8/27/14
Date

Bienville Building • 628 North 4th Street • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
Phone #: 225/342-9240 • Fax #: 225/342-9598 • www.MakingMedicaidBetter.com
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Appendix M: Development of Final Rates for July 1, 2015 through January 31, 2016

Rate Development Description

The below portrays the detail of the rate development based on the combined Prepaid, Shared Savings, and Legacy Medicaid/FFS (Chisholm, HCBS, and LaHIPP) data. The rate development exhibit takes the base data that was provided in Attachment 1 of the data book issued on January 31, 2015, and applies the various rate setting adjustments. The columns in the exhibit are as follows:

Base Data – The base data in these columns includes IBNR.
MMs – MMs for the CY13 period.
PMPM – Computed as the total paid amount divided by the total MMs. Statewide PMPMs were used where appropriate, as indicated in the rate certification letter.

Base Data Adjustments:
Annual Trend - (Low & High) – Annualized trend that is equivalent to the trend factor applied to the base data.
Trend Factor - (Low & High) – Trend factor that is equivalent to the compounded annualized trend applied to the base data.
Base Period Adj. – Overall base period adjustment applied to both the low and high PMPMs. A list of the data source-specific adjustments and the level of detail in which they were applied can be found in the table below:

Base Period Adjustments		
Prepaid	**Shared/FFS**	**LaHIPP**
	Fraud and Abuse Adjustment (statewide adj.)	Fraud and Abuse Adjustment (statewide adj.)
Fee Schedule Adjustment (hospital specific adj.)	Fee Schedule Adjustment (hospital specific adj.)	Fee Schedule Adjustment (hospital specific adj.)
ACT 312 Adjustment (statewide adj.)	ACT 312 Adjustment (statewide adj.)	ACT 312 Adjustment (statewide adj.)
	Rx Rebate Adjustment (statewide adj.)	Rx Rebate Adjustment (statewide adj.)
ACT PCP Adjustment (category of service level adj.)	ACT PCP Adjustment (category of service level adj.)	
LBHP Adjustment (category of service level adj.)	LBHP Adjustment (category of service level adj.)	LBHP Adjustment (category of service level adj.)

Base Period Adjustments		
Prepaid	**Shared/FFS**	**LaHIPP**
Retro-activity Adjustment (rate cell level adj.)	Retro-activity Adjustment (rate cell level adj.)	Retro-activity Adjustment (rate cell level adj.)
NEMT Adjustment (rate cell level adj.)		

Managed Care Adj. Factor (Low & High) – Low and high managed care savings factors applied to the corresponding low and high PMPMs. A list of the data source-specific adjustments and the level of detail in which they were applied can be found in the table below:

Managed Care Adjustments		
Prepaid	**Shared/FFS**	**LaHIPP**
Managed Care Savings*	Managed Care Savings*	None
	GDR	

* Managed care savings adjustments were applied to previously unmanaged populations utilizing Legacy Medicaid/FFS claims (HCBS and Chisholm), as well as newly added services.

Outlier Add-on (PMPM) – PMPM added to account for outlier payments. Applies to both Low and High PMPMs.
Claims PMPM (Low) – Calculated as: K = [B *E * (1+G)*H] + J.
Claims PMPM (High) – Calculated as: L = [B * F * (1+G)*I] + J.
Fixed Admin Load (Low & High) – A PMPM adjustment added to the corresponding Low and High PMPMs.
Variable Admin Load (Low & High) – A percentage adjustment applied to the corresponding Low and High PMPMs.
Profit @ 2% – Provision in these rates has been made for a 2% risk margin.
Premium Tax @ 2.25% – Provision in these rates has been made for Louisiana's 2.25% premium tax.
PMPM After Admin - Low – Calculated as: S = (K * (1 + N) + M)/(1 – Q – R).
PMPM After Admin - High – Calculated as: T = (L * (1 + P) + O)/(1 – Q – R).

			Base Data		Base Data Adjustments							Outliers			Capitation Rate Load								Full Medicaid Pricing			
			A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X
Region Name	COA Desc	Rate Cell Code	MMs	PMPM	Annual Trend-Low	Annual Trend-High	Trend Factor-Low	Trend Factor-High	Base Period Adj.	Managed Care Adj. Factor-Low	Managed Care Adj. Factor-High	Outlier Add-on - PMPM	Claims PMPM-Low	Claims PMPM-High	Fixed Admin Load- Low (PMPM)	Variable Admin Load-Low (%)	Fixed Admin Load-High (PMPM)	Variable Admin Load-High (%)	Profit @ 2%	Premium Tax @ 2.25%	PMPM After Admin-Low	PMPM After Admin- High	FMP Add-On	Premium tax on FMP	Final Loaded Rates-Low	Final Loaded Rates-High
Gulf	SSI	Newborn, 0-2 Months	291	$ 19,478.95	0.4%	3.8%	1.01	1.08	-5.0%	1.00	1.00	$ 945.10	$ 19,605.45	$ 20,936.71	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 21,716.65	$ 23,191.46	$ 7,290.31	$ 167.81	$ 29,176.77	$ 30,649.57
Gulf	SSI	Newborn, 3-11 Months	1,790	$ 3,966.82	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	$ 63.79	$ 4,036.79	$ 4,304.79	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,461.42	$ 4,755.19	$ 848.08	$ 19.52	$ 5,329.02	$ 5,622.79
Gulf	SSI	Child, 1-18 Years	122,394	$ 292.96	2.9%	5.9%	1.06	1.13	-1.4%	0.98	0.99	$ 2.39	$ 302.71	$ 324.02	$ 10.89	4.4%	$ 11.67	4.4%	2.0%	2.25%	$ 341.49	$ 365.60	$ 42.41	$ 0.98	$ 384.88	$ 408.98
Gulf	SSI	Adult, 19+ Years	276,704	$ 681.20	2.9%	5.9%	1.06	1.13	0.4%	0.99	0.99	$ -	$ 717.35	$ 764.64	$ 10.89	4.3%	$ 11.67	4.4%	2.0%	2.25%	$ 783.04	$ 845.58	$ 218.56	$ 5.03	$ 1,016.63	$ 1,069.17
Gulf	Family and Children	Newborn, 0-2 Months	43,180	$ 1,149.57	0.7%	4.1%	1.01	1.09	-7.5%	1.00	1.00	$ 46.33	$ 1,122.09	$ 1,199.45	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,253.38	$ 1,339.71	$ 455.39	$ 10.48	$ 1,719.26	$ 1,805.59
Gulf	Family and Children	Newborn, 3-11 Months	104,549	$ 200.42	2.3%	5.8%	1.05	1.12	-10.6%	0.97	0.97	$ 0.21	$ 182.14	$ 196.37	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 211.71	$ 228.18	$ 34.70	$ 0.80	$ 247.21	$ 263.69
Gulf	Family and Children	Child, 1-18 Years	2,053,265	$ 89.50	3.0%	6.2%	1.06	1.13	-4.9%	0.95	0.96	$ 0.05	$ 86.08	$ 92.49	$ 10.89	4.7%	$ 11.67	4.8%	2.0%	2.25%	$ 105.54	$ 113.37	$ 14.16	$ 0.33	$ 120.02	$ 127.86
Gulf	Family and Children	Adult, 19+ Years	374,005	$ 214.94	2.9%	5.9%	1.06	1.13	1.7%	0.96	0.97	$ -	$ 223.22	$ 238.47	$ 10.89	4.8%	$ 11.67	4.8%	2.0%	2.25%	$ 255.89	$ 273.23	$ 64.56	$ 1.49	$ 321.77	$ 339.10
Gulf	Breast and Cervical Cancer	BCC, All Ages Female	3,702	$ 1,291.59	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	$ -	$ 1,460.86	$ 1,577.84	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,615.27	$ 1,744.92	$ 552.62	$ 12.72	$ 2,180.61	$ 2,310.26
Gulf	LaCHIP Affordable Plan	All Ages	9,457	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	$ -	$ 115.39	$ 124.22	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.41	$ 147.88	$ 16.71	$ 0.38	$ 154.51	$ 164.98
Gulf	HCBS Waiver	18 & Under, Male and Female	6,826	$ 1,357.71	2.0%	4.6%	1.04	1.10	0.5%	0.95	0.97	$ -	$ 1,343.79	$ 1,460.38	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,469.28	$ 1,618.62	$ 51.75	$ 1.19	$ 1,542.22	$ 1,671.56
Gulf	HCBS Waiver	19+ Years, Male and Female	21,296	$ 509.87	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	$ -	$ 470.37	$ 510.93	$ 10.89	4.2%	$ 11.67	4.3%	2.0%	2.25%	$ 523.50	$ 568.78	$ 76.05	$ 1.80	$ 603.34	$ 648.62
Gulf	Chisholm Class Members	Chisholm, All Ages Male & Female	15,710	$ 774.94	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	$ -	$ 753.39	$ 825.52	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 838.14	$ 910.40	$ 67.87	$ 1.56	$ 907.57	$ 987.84
Gulf	Maternity Kickpayment	Maternity Kickpayment, All Ages	10,987	$ 5,122.05	0.0%	2.0%	1.00	1.04	-2.6%	1.00	1.00	$ -	$ 5,092.15	$ 5,305.63	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 5,640.00	$ 5,977.03	$ 2,984.49	$ 68.70	$ 8,693.19	$ 9,030.22
Capital	SSI	Newborn, 0-2 Months	168	$ 19,478.95	0.4%	3.8%	1.01	1.08	-5.0%	1.00	1.00	$ 945.10	$ 19,605.45	$ 20,936.71	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 21,716.65	$ 23,191.46	$ 8,066.08	$ 186.12	$ 29,990.86	$ 31,463.67
Capital	SSI	Newborn, 3-11 Months	1,491	$ 3,966.82	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	$ 63.79	$ 4,036.79	$ 4,304.79	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,461.42	$ 4,755.19	$ 944.51	$ 21.74	$ 5,427.68	$ 5,721.44
Capital	SSI	Child, 1-18 Years	89,519	$ 344.20	3.0%	5.9%	1.06	1.13	1.5%	0.98	0.99	$ 2.39	$ 365.03	$ 390.59	$ 10.89	4.4%	$ 11.67	4.4%	2.0%	2.25%	$ 409.50	$ 438.24	$ 18.76	$ 0.43	$ 428.69	$ 457.43
Capital	SSI	Adult, 19+ Years	210,439	$ 745.67	3.0%	5.9%	1.06	1.13	4.1%	0.99	0.99	$ -	$ 813.72	$ 867.77	$ 10.89	4.3%	$ 11.67	4.4%	2.0%	2.25%	$ 898.08	$ 958.00	$ 139.76	$ 3.22	$ 1,041.06	$ 1,100.97
Capital	Family and Children	Newborn, 0-2 Months	38,789	$ 1,156.11	0.6%	4.0%	1.01	1.09	-6.4%	1.00	1.00	$ 46.33	$ 1,140.87	$ 1,220.31	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,274.05	$ 1,362.67	$ 573.32	$ 13.20	$ 1,860.57	$ 1,949.19
Capital	Family and Children	Newborn, 3-11 Months	94,611	$ 223.96	2.1%	5.6%	1.05	1.12	-7.5%	0.97	0.97	$ 0.21	$ 209.26	$ 225.88	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 241.58	$ 260.47	$ 24.96	$ 0.57	$ 267.11	$ 286.00
Capital	Family and Children	Child, 1-18 Years	1,863,396	$ 96.04	3.2%	6.3%	1.07	1.14	-1.8%	0.94	0.95	$ 0.05	$ 94.83	$ 101.98	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 114.97	$ 123.60	$ 11.52	$ 0.27	$ 126.75	$ 135.38
Capital	Family and Children	Adult, 19+ Years	268,984	$ 248.77	3.0%	5.9%	1.06	1.13	6.0%	0.96	0.97	$ -	$ 268.79	$ 286.95	$ 10.89	4.7%	$ 11.67	4.7%	2.0%	2.25%	$ 305.40	$ 326.10	$ 62.59	$ 1.44	$ 369.43	$ 390.13
Capital	Breast and Cervical Cancer	BCC, All Ages Female	3,946	$ 1,291.59	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	$ -	$ 1,460.86	$ 1,577.84	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,615.27	$ 1,744.92	$ 546.25	$ 12.57	$ 2,174.10	$ 2,303.74
Capital	LaCHIP Affordable Plan	All Ages	10,487	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	$ -	$ 115.39	$ 124.22	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.41	$ 147.88	$ 17.95	$ 0.41	$ 155.77	$ 166.24
Capital	HCBS Waiver	18 & Under, Male and Female	7,164	$ 1,357.71	2.0%	4.6%	1.04	1.10	0.5%	0.95	0.97	$ -	$ 1,343.79	$ 1,460.38	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,469.28	$ 1,618.62	$ 50.17	$ 1.15	$ 1,540.61	$ 1,669.94
Capital	HCBS Waiver	19+ Years, Male and Female	21,638	$ 509.87	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	$ -	$ 470.37	$ 510.93	$ 10.89	4.2%	$ 11.67	4.3%	2.0%	2.25%	$ 523.50	$ 568.78	$ 76.02	$ 1.75	$ 601.27	$ 646.55
Capital	Chisholm Class Members	Chisholm, All Ages Male & Female	15,831	$ 774.94	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	$ -	$ 753.39	$ 825.52	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 838.14	$ 910.40	$ 68.76	$ 1.58	$ 909.48	$ 988.75
Capital	Maternity Kickpayment	Maternity Kickpayment, All Ages	9,772	$ 4,497.81	0.0%	2.0%	1.00	1.04	0.3%	1.00	1.00	$ -	$ 4,510.47	$ 4,700.44	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 4,995.73	$ 5,295.68	$ 2,977.87	$ 68.54	$ 8,042.15	$ 8,292.09
South Central	SSI	Newborn, 0-2 Months	217	$ 19,478.95	0.4%	3.8%	1.01	1.08	-5.0%	1.00	1.00	$ 945.10	$ 19,605.45	$ 20,936.71	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 21,716.65	$ 23,191.46	$ 7,410.29	$ 170.57	$ 29,299.51	$ 30,772.32
South Central	SSI	Newborn, 3-11 Months	1,692	$ 3,966.82	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	$ 63.79	$ 4,036.79	$ 4,304.79	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,461.42	$ 4,755.19	$ 859.85	$ 19.79	$ 5,341.06	$ 5,634.83
South Central	SSI	Child, 1-18 Years	91,726	$ 344.01	3.4%	6.2%	1.07	1.13	0.4%	0.98	0.99	$ 2.39	$ 364.84	$ 389.34	$ 10.89	4.1%	$ 11.67	4.1%	2.0%	2.25%	$ 407.86	$ 436.37	$ 38.35	$ 0.88	$ 447.09	$ 474.60
South Central	SSI	Adult, 19+ Years	247,354	$ 679.80	3.0%	5.9%	1.06	1.13	1.0%	0.99	0.99	$ -	$ 720.34	$ 768.13	$ 10.89	4.4%	$ 11.67	4.4%	2.0%	2.25%	$ 796.60	$ 849.68	$ 159.91	$ 3.68	$ 960.19	$ 1,013.28
South Central	Family and Children	Newborn, 0-2 Months	43,502	$ 1,250.37	0.7%	4.1%	1.01	1.09	-6.8%	1.00	1.00	$ 46.33	$ 1,224.44	$ 1,309.36	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,366.54	$ 1,461.21	$ 665.66	$ 15.78	$ 2,067.98	$ 2,162.65
South Central	Family and Children	Newborn, 3-11 Months	104,512	$ 223.52	2.4%	5.7%	1.05	1.12	-8.3%	0.96	0.97	$ 0.21	$ 207.58	$ 223.51	$ 10.89	5.2%	$ 11.67	5.2%	2.0%	2.25%	$ 239.49	$ 257.81	$ 44.86	$ 1.03	$ 285.49	$ 303.81
South Central	Family and Children	Child, 1-18 Years	2,038,315	$ 102.68	3.3%	6.3%	1.07	1.14	-3.0%	0.94	0.95	$ 0.05	$ 100.49	$ 107.86	$ 10.89	4.5%	$ 11.67	4.5%	2.0%	2.25%	$ 121.06	$ 129.53	$ 13.42	$ 0.31	$ 134.79	$ 143.67
South Central	Family and Children	Adult, 19+ Years	285,454	$ 232.89	2.9%	5.9%	1.06	1.13	2.8%	0.97	0.97	$ -	$ 245.52	$ 262.05	$ 10.89	4.8%	$ 11.67	4.8%	2.0%	2.25%	$ 280.15	$ 299.10	$ 57.77	$ 1.33	$ 339.25	$ 358.20
South Central	Breast and Cervical Cancer	BCC, All Ages Female	2,893	$ 1,291.59	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	$ -	$ 1,460.86	$ 1,577.84	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,615.27	$ 1,744.92	$ 560.64	$ 12.90	$ 2,188.81	$ 2,318.46
South Central	LaCHIP Affordable Plan	All Ages	12,222	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	$ -	$ 115.39	$ 124.22	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.41	$ 147.88	$ 18.72	$ 0.43	$ 156.56	$ 167.04
South Central	HCBS Waiver	18 & Under, Male and Female	6,665	$ 1,357.71	2.0%	4.6%	1.04	1.10	0.5%	0.95	0.97	$ -	$ 1,343.79	$ 1,460.38	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,469.28	$ 1,618.62	$ 53.27	$ 1.23	$ 1,543.77	$ 1,673.11
South Central	HCBS Waiver	19+ Years, Male and Female	23,110	$ 509.87	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	$ -	$ 470.37	$ 510.93	$ 10.89	4.2%	$ 11.67	4.3%	2.0%	2.25%	$ 523.50	$ 568.78	$ 76.83	$ 1.81	$ 604.14	$ 649.42
South Central	Chisholm Class Members	Chisholm, All Ages Male & Female	16,556	$ 774.94	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	$ -	$ 753.39	$ 825.52	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 838.14	$ 910.40	$ 68.07	$ 1.57	$ 907.77	$ 988.04
South Central	Maternity Kickpayment	Maternity Kickpayment, All Ages	10,504	$ 4,368.34	0.0%	2.0%	1.00	1.04	2.5%	1.00	1.00	$ -	$ 4,477.23	$ 4,665.81	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 4,959.93	$ 5,167.33	$ 2,903.03	$ 59.92	$ 7,821.88	$ 7,830.28
North	SSI	Newborn, 0-2 Months	239	$ 19,478.95	0.4%	3.8%	1.01	1.08	-5.0%	1.00	1.00	$ 945.10	$ 19,605.45	$ 20,936.71	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 21,716.65	$ 23,191.46	$ 7,703.95	$ 177.33	$ 29,598.93	$ 31,072.74
North	SSI	Newborn, 3-11 Months	1,678	$ 3,966.82	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	$ 63.79	$ 4,036.79	$ 4,304.79	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,461.42	$ 4,755.19	$ 874.61	$ 20.13	$ 5,356.16	$ 5,649.93
North	SSI	Child, 1-18 Years	100,260	$ 295.72	3.0%	5.8%	1.06	1.12	3.7%	0.98	0.99	$ 2.39	$ 322.88	$ 344.03	$ 10.89	4.4%	$ 11.67	4.5%	2.0%	2.25%	$ 363.57	$ 387.50	$ 43.09	$ 0.99	$ 407.65	$ 431.58
North	SSI	Adult, 19+ Years	212,259	$ 639.16	2.8%	5.8%	1.06	1.12	0.5%	0.99	0.99	$ -	$ 672.15	$ 717.13	$ 10.89	4.5%	$ 11.67	4.5%	2.0%	2.25%	$ 744.90	$ 794.96	$ 172.71	$ 3.98	$ 921.58	$ 971.65
North	Family and Children	Newborn, 0-2 Months	32,253	$ 1,240.40	0.7%	4.1%	1.01	1.09	-4.4%	1.00	1.00	$ 46.33	$ 1,244.56	$ 1,331.66	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,388.93	$ 1,486.03	$ 572.27	$ 13.17	$ 1,974.38	$ 2,071.47
North	Family and Children	Newborn, 3-11 Months	80,214	$ 205.87	2.4%	5.8%	1.05	1.12	-4.9%	0.97	0.97	$ 0.21	$ 198.77	$ 213.95	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 229.93	$ 247.45	$ 32.11	$ 0.74	$ 262.78	$ 280.30
North	Family and Children	Child, 1-18 Years	1,597,962	$ 97.14	3.1%	6.2%	1.06	1.13	-1.1%	0.96	0.96	$ 0.05	$ 97.72	$ 94.08	$ 10.89	4.8%	$ 11.67	4.8%	2.0%	2.25%	$ 107.37	$ 115.15	$ 13.49	$ 0.31	$ 121.17	$ 128.95
North	Family and Children	Adult, 19+ Years	213,631	$ 219.65	2.8%	5.9%	1.06	1.13	2.2%	0.97	0.97	$ -	$ 229.95	$ 245.85	$ 10.89	4.9%	$ 11.67	5.0%	2.0%	2.25%	$ 263.39	$ 281.66	$ 59.76	$ 1.38	$ 324.52	$ 342.79
North	Breast and Cervical Cancer	BCC, All Ages Female	2,365	$ 1,291.59	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	$ -	$ 1,460.86	$ 1,577.84	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,615.27	$ 1,744.92	$ 575.28	$ 13.24	$ 2,203.79	$ 2,333.44
North	LaCHIP Affordable Plan	All Ages	6,545	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	$ -	$ 115.39	$ 124.22	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.41	$ 147.88	$ 18.73	$ 0.43	$ 156.57	$ 167.05
North	HCBS Waiver	18 & Under, Male and Female	4,164	$ 1,357.71	2.0%	4.6%	1.04	1.10	0.5%	0.95	0.97	$ -	$ 1,343.79	$ 1,460.38	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,469.28	$ 1,618.62	$ 54.40	$ 1.25	$ 1,544.93	$ 1,674.26
North	HCBS Waiver	19+ Years, Male and Female	17,320	$ 509.87	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	$ -	$ 470.37	$ 510.93	$ 10.89	4.2%	$ 11.67	4.3%	2.0%	2.25%	$ 523.50	$ 568.78	$ 79.93	$ 1.84	$ 605.27	$ 650.55
North	Chisholm Class Members	Chisholm, All Ages Male & Female	16,472	$ 774.94	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	$ -	$ 753.39	$ 825.52	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 838.14	$ 910.40	$ 68.56	$ 1.58	$ 908.28	$ 988.54
North	Maternity Kickpayment	Maternity Kickpayment, All Ages	8,132	$ 4,615.95	0.0%	2.0%	1.00	1.04	-0.2%	1.00	1.00	$ -	$ 4,605.18	$ 4,799.14	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 5,100.64	$ 5,314.99	$ 2,573.72	$ 59.24	$ 7,733.60	$ 7,947.96

Appendix N: 2015 Managed Care Rate Setting Consultation Guide

Section I. July 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
1. General Information	
A. A letter from the certifying actuary, who meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board, that certifies that the final capitation rates or rate ranges meet the standards in 42 CFR §438.6(c).	Please refer to the certification letter dated August 11, 2015. All following page and exhibit references are specific to this certification.
B. The final and certified capitation rates or the final and certified rate ranges for all rate cells and regions, as applicable.	Please refer to Appendix A for a summary of all rate ranges by rate cell and region.
C. Brief descriptions of:	
i. The specific state Medicaid managed care programs covered by the certification.	Please refer to page 1.
ii. The rating periods covered by the certification.	Please refer to page 1.
iii. The Medicaid populations covered through the managed care programs for which the certification applies.	A brief description can be found on pages 3-4. Appendix B encompasses a comprehensive list of Bayou Health's covered and excluded populations.
iv. The services that are required to be provided by the managed care plans.	A brief description can be found on pages 6-7. Appendix C encompasses a comprehensive list of Bayou Health's covered services.
2. Data	
A. A description of the data used to develop capitation rates. This description should include:	
i. The types of data used, which may include (but is not limited to) claims data, encounter data, plan financial data, or other Medicaid program data.	Please refer to page 2.
ii. The age of all data used.	Please refer to page 2.
iii. The sources of all data used.	Please refer to page 2.

Section I. July 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
iv. To the extent that a significant portion of benefits are provided through subcapitated arrangements, a description of the data received from the subcapitated plans or providers.	N/A
v. To the extent that claims or encounter data are not used or not available, an explanation of why that data was not used or was not available.	N/A
B. Information related to the availability and the quality of the data used:	
i. The steps taken by the actuary or by others (which may include but is not limited to the state Medicaid program or the managed care organizations) to validate or improve the quality and accuracy of the data.	Please refer to the base data adjustment section beginning on page 7.
ii. Any concerns that the actuary has over the availability or quality of the data.	The data certification shown in Appendix L has been provided by DHH, and its purpose is to certify the accuracy, completeness, and consistency of the base data.
C. Any information related to changes in data used when compared to the most recent rating period:	
i. Any new data sources used by the actuary since the last certification and any data sources that the actuary has not continued to use since the last certification.	Bayou Health Shared Savings claims experience is used as a new data source. The Bayou Health Prepaid program operated under an at-risk capitated arrangement, and the Shared Savings program was an enhanced Primary Care Case Management (ePCCM) program. Effective February 1, 2015, Bayou Health will begin operating as an at risk capitated program only.
ii. How the data sources used have changed since the last certification.	N/A
D. Any plans or efforts to improve the data sources used for future certifications and any new data sources that are expected to be available and potentially used for future certifications.	N/A
E. Any adjustments that are made to the data.	Please refer to the base data adjustment section beginning on page 7.

Section I. July 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
3. Projected Benefit Costs	
A. Covered services and benefits	
i. Any changes related to the benefits covered by the Medicaid managed care organizations since the last certification, including but not limited to:	
a. More or fewer state plan benefits covered by the Medicaid managed care organization.	Please refer to the new services section on page 6.
b. Requirements deemed necessary by the state to ensure access or proper delivery of covered services, for minimum or maximum levels of payment from managed care organizations to any providers or class of providers.	N/A
c. Requirements or conditions of any applicable waivers.	N/A
ii. For each change related to benefits covered, the estimated impact of the change on amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment.	Please refer to the covered services section beginning on page 6.
B. Projected benefit cost trends	
i. The projected change in benefit costs from the historical period to the rating period, or trend, including but not limited to:	
a. The methodologies used to develop projected benefit costs trends.	Please refer to the trend section beginning on page 17.
b. Any data used or assumptions made in developing projected benefit cost trends.	Please refer to the trend section beginning on page 17.
c. Any applicable comparisons to historical benefit cost trends or other program benefit cost trends.	Please refer to the trend section beginning on page 17.

Section I. July 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
d. The different components of projected benefit cost trends, including but not limited to changes in price (such as provider reimbursement rates) and changes in utilization (such as the volume of services provided).	Please refer to Appendices I1-I3.
e. Any other material adjustments to projected benefit cost trends, and a description of the data, assumptions, and methodologies used to determine those adjustments.	N/A
f. To the extent there are any differences, projected benefit cost trends by:	
i. Service or category of service.	Please refer to Appendices I1-I3.
ii. Rate cell or Medicaid population.	Please refer to Appendices I1-I3.
C. Other adjustments to projected benefit costs:	
i. Any other adjustments made to projected benefit costs excluding those described above, including but not limited to:	
a. The impact of managed care on the utilization on the unit costs of health care services.	Please refer to the managed care adjustments section beginning on page 19 and Appendices J1-J2.
b. Changes to projected benefit costs in the rating period outside of regular changes in utilization or unit cost of services.	Please refer to the program changes section beginning on page 14.
D. Final projected benefit costs by relevant level of detail (for example, by Medicaid population or by rate cell).	Please refer to Appendix M.
4. Projected Non-benefit Costs	
E. Non-benefit costs including but not limited to:	Please refer to the non-medical expense load section beginning on page 22.
i. Administrative costs.	
ii. Care management or coordination costs.	
iii. Provisions for:	
a. Cost of capital.	
b. Risk margin.	
c. Contingency margin.	

Section I. July 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
d. Underwriting gain.	
e. Profit margin.	
iv. Taxes, fees, and assessments.	
v. Any other material non-benefit costs.	N/A
5. Rate Range Development	
A. Any assumptions for which values vary in order to develop rate ranges.	Please refer to the trend and managed care adjustments sections beginning on page 19, the Shared Savings Rx claims section beginning on page 20 and the non-medical expense load section on page 22.
B. The values of each of the assumptions used to develop the minimum, the mid-point (as applicable), and the maximum of the rate ranges.	Please refer to sections related to trend assumptions, managed care adjustments, Shared Savings Rx adjustment, prospective program change adjustments, and non-medical expense load considerations.
C. A description of the data, assumptions, and methodologies that were used to develop the values of the assumptions for the minimum, the mid-point (as applicable), and maximum of the rate ranges.	Please refer to sections related to trend assumptions, managed care adjustments, Shared Savings Rx adjustment, prospective program change adjustments, and non-medical expense load considerations.
6. Risk and Contractual Provisions	
A. Risk adjustment processes.	Please see risk adjustment section on page 23.
B. Risk sharing arrangements, such as risk corridor or large claims pool.	Please see outliers section on page 21.
C. Medical loss ratio requirements, such as a minimum medical loss ratio requirement.	N/A
D. Reinsurance requirements.	N/A
E. Incentives or withhold amounts.	Please see federal health insurer fee section on page 23.

Section I. July 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
7. Other Rate Development Considerations	
A. All adjustments to the capitation rates, or to any portion of the capitation rates, should reflect reasonable, appropriate, and attainable costs in the actuary's opinion and must be included in the rate certification. CMS notes that adjustments that are performed at the end of the rate setting process without adequate justification might not be considered actuarially sound.	N/A
B. The final contracted rates should either match the capitation rates or be within the rate ranges in the actuarial certification. This is required in total and by each rate cell.	N/A. Certification of the rate range.

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MAKE TOMORROW, TODAY

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November 20, 2015

Subject: Louisiana Bayou Health Program – Specialized Behavioral Health (BH) Actuarial Certification for Capitation Rate Ranges Effective December 1, 2015 through January 31, 2016

Dear Jen:

The State of Louisiana (State) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop actuarially sound capitation rate ranges for use in the State's contracts with the managed care organizations (MCOs) for Medicaid Specialized BH services provided to Medicaid-eligible adults and children in the Bayou Health program. The rate ranges were developed for specialized BH services covered under the managed care program for Medicaid-eligible adults and children for the contract period, effective from December 1, 2015 through January 31, 2016 (rating period).

This letter presents an overview of the analyses and methodology used in Mercer's managed care rate range development for Medicaid services for the purpose of satisfying the requirements of the Centers for Medicare and Medicaid Services (CMS) in a manner consistent with CMS regulations, 42 CFR 438.6(c).

Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate, and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government-mandated assessments, fees and taxes, and the cost of capital.

This letter describes the development of the draft rate ranges in Appendix B. The assumptions detailed in the memo illustrate the development of the midpoint rates for each rate cell on a statewide basis. The regional development of the rate ranges is included in the Appendices, which include the individual impacts of the programmatic change adjustments by region and rate cell.

Program Overview

The Louisiana Behavioral Health Partnership (LBHP) began March 1, 2012, and has operated under an at-risk capitation contract for the Adult population since the program inception. The Children's program has been administered on a non-risk basis by the Prepaid Inpatient Health Plan (PIHP). Effective December 1, 2015, the specialized BH services will be covered under the contracts with the Bayou Health MCOs. The initial rating period will be December 1, 2015 through January 31, 2016 to align with the remainder of the current Bayou Health rating period. Effective February 1, 2016, the specialized BH services will be integrated into the overall Bayou Health rating structure.

Separate capitation payments will be made for specialized behavioral health services effective December 1, 2015. The MCOs will continue to receive a payment for prior Bayou Health covered services under the Bayou Health rate cell structure. In addition, a separate payment will be made for eligible individuals for their specialized behavioral services under the current LBHP rate cell structure as outlined later in this letter.

Covered Populations

Bayou Health covers a broad array of Medicaid eligible populations. Specific information on the covered populations is contained in the contract. The following categories of aid (COA) are covered for a BH capitated payment under the contract and considered in rate setting:

- Non-Disabled Adults, Ages 21+
- Disabled Adults, Ages 21+
- Dually Eligibles, All Ages
- Non-Disabled Children, Ages 0-20
- Foster Care and Disabled Children, Ages 0-20

Mercer summarized the specialized behavioral health service utilization and cost data for the Medicaid eligible individuals into the rate cell structure. This structure is based on the prior LBHP rate structure for specialized BH services from Mercer's review of the historical cost and utilization patterns in the available experience.

The historical BH costs vary by age and eligibility category. Separate rate cells were designed for the Child and Adult populations. Non-Disabled populations have significantly lower BH costs compared to Disabled/Foster Care populations. As such, separate rate cells were created for the non-Disabled and Disabled/Foster Care populations. The dually eligible population is eligible for services where Medicare is the primary payer. As the Medicare crossover services will be excluded from the Bayou Health capitated program, a separate rate cell was necessary to address

the cost differences for the dually eligible populations. Due to the small number of dual eligibles under the age of 21, Mercer included all dual eligibles regardless of age into a single rate cell.

Populations that remain fee-for-service (FFS) or part of the non-risk program and are not covered under the capitation payment are as follows:

- Eligible under the Refugee Cash/Medical Assistance program
- Eligible under the Medicare Savings Program (Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, Qualified Individuals, and Qualified Disabled Working Individuals)
- Eligible under the Emergency Services Only program (aliens who do not meet Medicaid citizenship/ 5-year residency requirements)
- Eligible under the Long-Term Care Medicare Co-insurance program
- Eligible under the Section 1115 Greater New Orleans Community Health Connection Waiver
- Eligible under the Family Planning Eligibility Option (FPEO) that provides family-planning-services
- Eligible under the Program of All-Inclusive Care for the Elderly (PACE), a community-based alternative to placement in a nursing facility that includes a complete “managed care” type benefit combining medical, social and long-term care services
- Adults residing in Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD)
- Non-Medicaid adult on the eligibility file who is eligible for a Low-Income Subsidy program administered by the Social Security Administration
- Any Medicaid eligible person during a period of incarceration

Covered Services

The Bayou Health program will cover a broad array of specialized mental health and addiction services, including the following services covered under the State Plan:

- Inpatient Psychiatric Hospital services
- Psychiatric Emergency Room services
- Outpatient Psychiatric services
- Crisis Intervention services
- Community Psychiatric Support services
- Addiction services.
- Assertive Community Treatment
- Multi-systemic Treatment
- Medical Physician / Psychiatrist / Nurse Practitioner

- Psychosocial Rehabilitation
- Other BH Professional (Mental Health (MH) Providers and Clinics, Nurses, and Other Licensed Providers)
- Federally Qualified Health Center (FQHC)
- Psychiatric Residential Treatment Facility
- Therapeutic Group Home
- 1915(b)(3) Services - Case Conference

Medicaid eligibles receive Physical Health and other Medicaid-covered services from the Bayou Health MCOs or through the State's fee-for-service (FFS) program. The acute care portion of Bayou Health includes coverage for prescription drugs for both Physical Health and BH medications. As such, prescription drugs are not included in these capitation rate ranges nor any prescription drug considerations discussed in this letter.

Children who are enrolled in the CSoC 1915(c) waiver program or included in the 1915(b)(3) CSoC program will only be in Bayou Health for Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (TGH) and Substance Use Disorder (SUD) Residential services in terms of BH coverage. The other specialized BH services will be managed by Magellan. More information on CSoC considerations is included later in this letter. The State maintains a list of the individuals enrolled in the CSoC program as well as a waiver segment code on the eligibility records. This logic was utilized to exclude the requisite services from the rate development.

For the dually eligible individuals, Medicare crossover claims have been excluded from the base data and rate development. These services are paid directly by the State after coordinating with Medicare and have been excluded from the services covered under the capitation rates.

This actuarial certification is specific to the capitation rates for the Specialized BH portion of the Bayou Health program effective December 1, 2015 through January 31, 2016.

Rate Methodology

Overview

Capitation rate ranges for the Specialized BH services were developed in accordance with rate-setting guidelines established by CMS. One of the key considerations in the development of the rate ranges was the base data. The primary base data used to develop the rate ranges were managed care encounter data provided by the State.

The encounter data are submitted by the PIHP to the State's fiscal agent, Molina. Molina provided an extract of the encounter data to Mercer in March 2014 for use in the preparation of the Data

Book. The encounter data extract included recipient-level claims and utilization detail. The eligibility information used in the encounter data analysis is summarized from the State's eligibility file, which outlines enrollment segments for each member. The contents of the Data Book are consistent with the data summarized for the current LBHP rate period of March 2015 through November 2015 with the exception of additional breakouts by region. The decision was made to utilize the same base data for the December 2015 through January 2016 rate development and prepare updated Data Books for Specialized BH services with the use of 2014 data for the February 2016 rates consistent with the plan for the Bayou Health program.

Mercer reviewed the Specialized BH contract to identify covered services. Then, the following adjustments to the base data were evaluated:

- Trend factors to forecast the expenditures and utilization for the rating period
- Programmatic changes not reflected in the base data
- Managed care adjustments
- Administration and risk margin loading

The various steps in the rate range development are described in the following paragraphs.

Base Data

The base data used to establish the capitation rates are summarized in the Data Book. The Data Book contains demographic, cost, and utilization data related to specialized BH services only. The Data Book is included along with this certification letter.

PIHP Encounter Data

The State provided Mercer with 2012 and CY 2013 encounter data submitted by the PIHP for services delivered to adults (on an at-risk basis) and children (on a non-risk basis). Mercer used this data to support the rate calculations. After review of the data, Mercer determined that actual experience incurred from January 1, 2013 through December 31, 2013, paid through February 2014 was suitable for rate development and as noted consistent with the Data Book utilized in the development of the March 2015 through November 2015 rates. Data prior to this time period reflected lower volume of services as the adult managed care program began in March, 2012.

Mercer performed a review of the PIHP encounter data for the State. This review included:

- Checks for month-to-month consistency of claims and eligibility
- Checks for reasonability of the utilization and unit cost information
- Comparisons to PIHP financial data and historical FFS data

- Analysis of claims lag triangles

Note that Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design, and financial data and information supplied by the State and the PIHP. The State and the PIHP are solely responsible for the validity and completeness of these supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion they are appropriate for the intended rate-setting purpose. However, if the data and information are incomplete and/or inaccurate, the values shown in this report may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this report.

Base Data Adjustments

After analysis of historical payment patterns and discussions with the State, Mercer was able to assess the accuracy and completeness of the information and estimate any necessary adjustments. Mercer applied adjustments to the encounter data so that they reflected the populations and services covered under the contract, including the considerations of the new mixed services protocol effective March 2015.

Mercer reviewed the PIHP encounter data to ensure they were appropriate for the populations and services covered. The following items were not included in the encounter data or were already deducted from the paid amounts in the encounter data, and therefore no further adjustment was necessary:

- Third-party liability recoveries are already deducted from the payments used in rate setting. No material amounts were paid outside the claim system.
- Copayments, coinsurance, and deductibles
- Disproportionate Share Hospital payments (AA.3.5)

Mercer understands that payment rates for Graduate Medical Education (GME) hospitals included in the claim data are consistent with applicable State fee schedule rates which do not include the GME portion of Inpatient payments. Because Mercer relied on the payment information included in the dataset submitted by the PIHP, the GME portion of Inpatient payments are not included in the base data and won't be included in the capitation rates. The State will continue to make supplemental payments to hospitals for GME, as applicable.

Completion factors were applied to the encounter data to reflect claims not yet adjudicated (see step AA.3.14 in the CMS Rate-setting Checklist). Financial lags were available separately for

Inpatient and all other services. Mercer compared the results of the encounter completion analysis to the financial lags to evaluate whether an encounter underreporting adjustment was necessary. .

For more information on the adjustments listed above, please refer to Section 4 of the Data Book included in this submission.

Other Base Data Considerations

Excluded Populations and Services

Certain adjustments were not necessary due to exclusions made in the data summarization process. These adjustments include:

- **Excluding non-covered populations** (for example, qualified Medicare beneficiaries, Medically Needy spend-down individuals, etc., see step AA.2.1) — Please see Data Book Section 2 for more information.
- **Excluding non-covered services** (for example, Physical Health services, 1915(c) Waiver services, etc., see step AA.3.1) — Please see Data Book Section 3 for more information.

State Plan Service Considerations

The rate development considers expected costs for State Plan services delivered in a managed care environment. In some cases for the Adult population, the prior PIHP provided an approved service in-lieu-of a State Plan service. In these cases, Mercer has reflected the costs of the State Plan service and applied a managed care discount to arrive at total costs consistent with actual paid expenses. The table below identified the key services priced using this methodology.

2013 Paid Encounter Claims

State Plan	In Lieu Of	Non-Dual	Dual Eligble	Encounter Unit Cost	State Plan Unit Cost	Managed Care Discount
Inpatient	IP IMD (21-64)	$ 13,021,841	N/A	$ 489.45	$ 646.94	-24%
Acute Detox Facilities	SUD Residential	$ 4,163,515	$ 338,654	$ 67.14	$ 145.51	-54%
ER	Crisis	$ 141,408	$ 25,365	$ 81.79	$ 249.12	-67%

The unit costs for the in-lieu-of services was less than the alternative State Plan services, demonstrating the cost-effectiveness of these services.

New Mixed Service Protocol

The State has implemented changes to the services classified as specialized behavioral health services. Previously, Institutional services (Inpatient, Outpatient, and ER) were covered as specialized behavioral health services under LBHP if the claim was identified with a qualifying BH

diagnosis. Effective March 1, 2015, only claims from BH facilities or services provided by BH specialists will be classified as specialized behavioral health services, as described below.

- **Inpatient and Outpatient services —** BH facilities include freestanding psychiatric hospitals, general hospital distinct part psych (DPP) units, MH clinics and rehab facilities, substance use disorder facilities, residential settings, and other BH providers.
- **Professional BH services —** BH specialists include physicians, doctors of osteopathic medicine (DO), and advanced practice registered nurses with specialty in psychiatry, as well as psychologist and licensed MH professionals. Unlicensed BH providers are covered for Rehab services only. Coverage includes services provided by BH specialists regardless of service location, including consults and services provided by a BH specialist in a general Inpatient or ER setting. Servicing provider specialty (as opposed to billing provider) is used to determine classification of specialized behavioral health services. Services billed and provided separately by non-BH specialists (such as general nurse practitioner) where place of service is a BH facility are classified as Acute care services under Bayou Health and not classified as specialized behavioral health services.
- **ER Services —** ER services are not classified as specialized BH, except for professional components billed by BH specialists or when the facility component is billed by a BH facility (for example, a freestanding psychiatric facility or DPP unit billing revenue code 450).
- **Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services —** FQHC and RHC services are covered in full when any service provided during a visit is provided by a BH specialist. All other FQHC and RHC visits are not classified as specialized BH services.

The details of the mixed service protocol are summarized in the Data Book. The net impact of the changes to the mixed service protocol resulted in approximately $13.8 M of historical 2013 encounter data being reclassified as basic BH, which was already accounted for in the Bayou Health February 2015 rates.

Trend

Trend is an estimate of the change in the overall cost of providing health care services over a finite period of time (AA.3.10). Capitation rate ranges are actuarial projections of future contingent events and a trend factor is necessary to estimate the expenses of providing health care services in the future rating period.

To develop the December 1, 2015 through January 31, 2016 rate ranges using the CY 2013 encounter data as a base, Mercer projected costs based on a review of historical experience, emerging trends, and expected costs and utilization during the rating period. The midpoint of the

base data was July 1, 2013. The midpoint of the rating period is January 1, 2016, which necessitated 30 months of total trend to project from the base time period to the rating period.

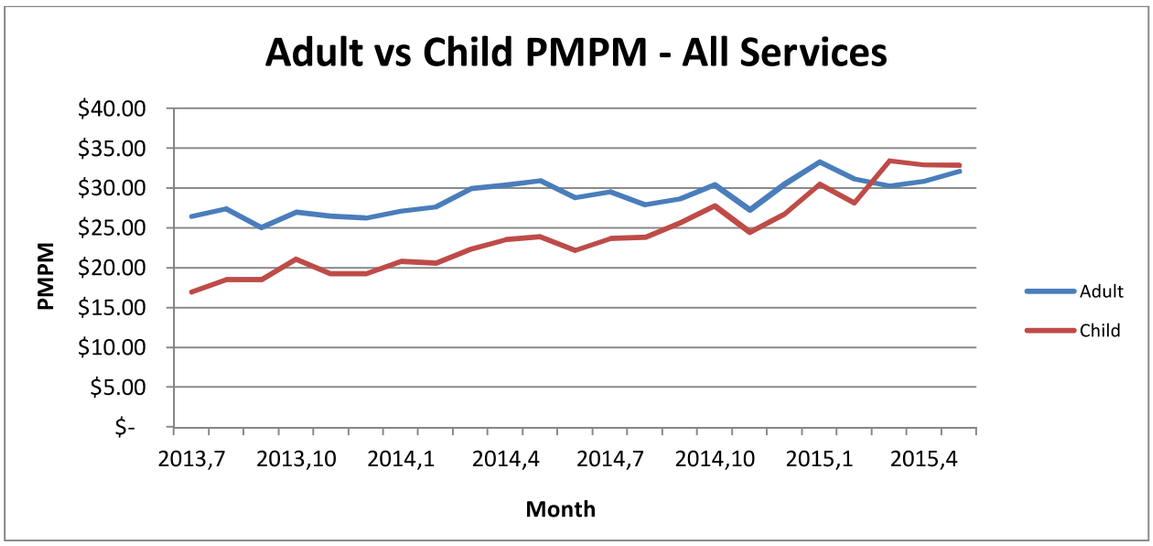
Trend Data Sources

As more recent utilization and cost data has become available for Specialized BH services beyond the 2013 base data period, Mercer focused the trend analysis on the actual trend patterns from the midpoint of the base data period (July 2013) through the most recently available data through May 2015.Mercer created rolling-average Per Member Per Month (PMPM) summaries using the managed care encounter data for various time intervals (three month, six month, nine month and 12 month) by region, rating group, and major service category.

The trend analysis focused on the emerging PMPM trends, which encompassed both the unit cost and utilization components. Each rate cell in the State experience exhibited unique trends reflecting the underlying characteristics of the population and the mix of services received. The CY 2014 and emerging 2015 data indicated significant increases in utilization for many services. The trends for the community psychiatric and psychosocial rehabilitation service categories exhibited significant PMPM growth from the beginning of 2013 through May 2015. Given the limited projection period from the end of the available data (May 2015) through the midpoint of the rate period (January 1, 2016), Mercer assumed prospective trend patterns for the Specialized BH services consistent with the trend levels exhibited in the emerging data through May 2015.

Mercer reviewed trend information in other state's Medicaid programs and national indices as reasonability checks. These sources were reviewed, but the trend observations in the LA specific program experience were determined to be the most credible base for future projections. The significant utilization trends exhibited in the LA program experience are higher than other state programs that have higher established historical utilization levels.

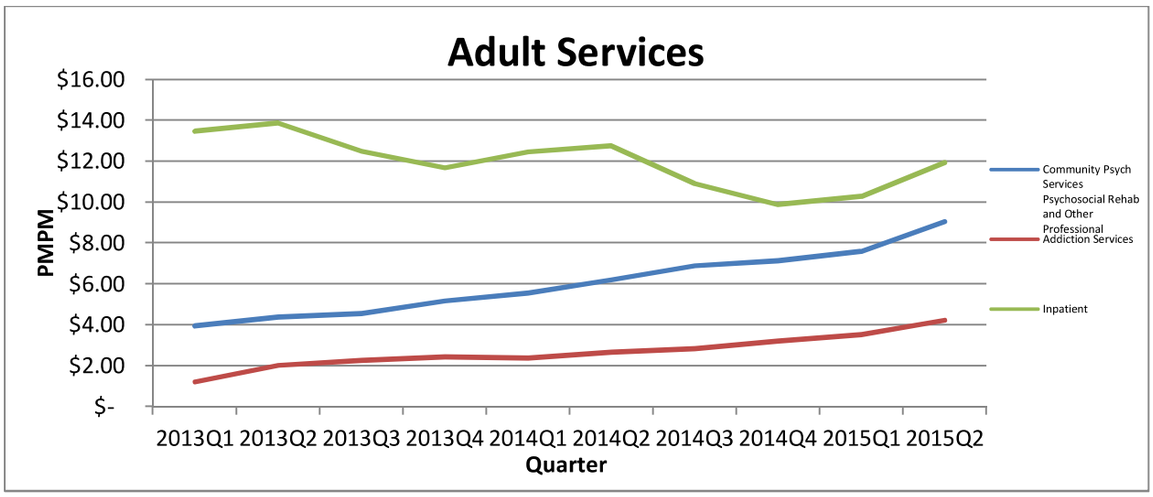
Trends observed in the data through May 2015 indicate significant growth in the overall service utilization for all regions and rate cells, particularly the children's services. The graphs below show quarterly PMPM growth between CY 2013 and May 2015.



The PMPM progression illustrates that, while Adult trends appeared to mitigate during 2014 from the historic growth, trends in the first two quarters of 2015 have re-emerged for certain services. While children's services have historically been low compared to that of adults, recent utilization growth has driven notably high PMPM trends in 2014 and 2015. Mercer developed trend assumptions at the region and category of service level based on the specific trend patterns reflected in the data. Generally, the trend drivers were consistent by region. As such, the trend observations are provided below on a statewide basis specific to each population.

Adult Trend Observations

The adult trends are primarily driven by utilization growth in Community Psych, Psychosocial Rehab and Addiction Services throughout 2013 and into the first two quarters of 2015. There was significant growth of community based services starting in CY 2013 that has continued into 2015. Utilization of addiction treatment services has experienced more significant trends in 2015. The higher trends for community-based services were partially offset in 2014 by decreasing utilization of Inpatient services. The table below shows the trends in the historic quarterly adult PMPMs for these three categories of service.



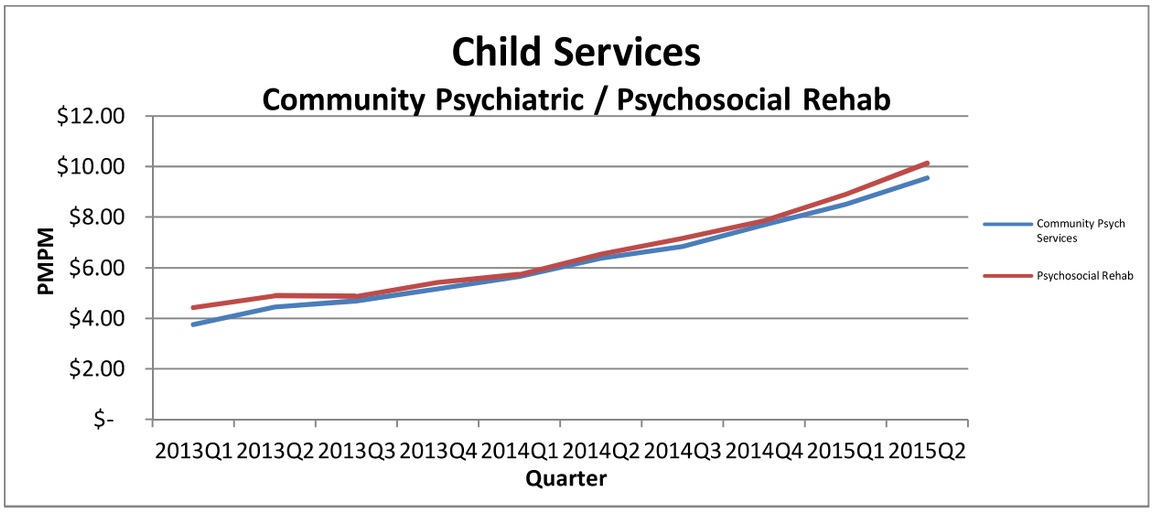
The composite annual PMPM trends for each category of service for adults are listed in the table below. Mercer grouped similar categories of service that had similar trend patterns together to increase credibility for the smaller categories of service. Trends were applied for 30 months from the midpoint of CY 2013 to the midpoint of the December 1, 2015 through January 31, 2016 rating period.

Categories of Service	Annualized PMPM Trend
Inpatient, Inpatient Detox	-3.5%
Emergency Room, Outpatient, Medical Physician/Psychiatrist, Other Professional, FQHC,	18.2%
Community Psychiatric Support, Psychosocial Rehab, ACT	22.7%
Addiction Services	39.5%
Crisis Intervention, MST, and Other Services	31.3%
Total	11.5%

Child Trend Observations

The Child trends are driven by utilization growth in Community Psych and Psychosocial Rehab, and recently Other Professional services. Significant growth in these services was observed throughout the entire period between CY 2013 and the early months of CY 2015. Based on the continued growth into CY 2015, Mercer expects higher trends to continue throughout CY 2015, and into the rating period for children's services. The table below shows the trends in the historic

quarterly child PMPMs for the categories of service that are driving the growth in children's services.



The overall trend projection for each category of service for children is listed in the table below.

Categories of Service	Annualized PMPM Trend
Inpatient, Inpatient Detox	9.0%
Emergency Room, Outpatient, Medical Physician/Psychiatrist, Other Professional, FQHC,	18.6%
Community Psychiatric Support, Psychosocial Rehab, ACT	42.1%
PRTF	16.6%
Crisis Intervention, MST, Addiction Services, Other Services, Therapeutic Group Home	12.6%
Total	29.7%

The overall annualized projected BH service trend assumption is 11.5% for adults, 29.7% for children, or 24.4% overall including increases in both utilization and general cost inflation. Mercer recognizes that prospective trends can vary based, on fluctuations in service utilization and has considered this variability in the development of the trend ranges. To project the final rate ranges, Mercer varied the trend assumptions by varying the annualized trend from an overall annual rate of 21.1% at the Lower Bound to 27.0% at the Upper Bound. The Lower Bound represents lower

rates of growth as initial period trends moderate and the Upper Bound represents continued utilization growth at the higher levels observed during the initial years of the program.

Programmatic Changes

Mercer and the State discussed programmatic changes that may impact the managed care contract. This included a review of changes to the State's hospital fee schedules, adjustments to account for changes in population mix, rate changes for certain providers after the 2013 base data time period, and adjustments for final decisions on program coverage after the development of the base data. The following sections describe the analysis for each program change as well as the statewide impact of the adjustment. Mercer has included Appendix C which details the percentage and PMPM impact of each adjustment by region and rate cell.

Inpatient Hospital Fee Schedules

Inpatient Hospital fee schedules have changed in Medicaid from the levels reported in the base data. Most notably, rates for certain public hospitals changed as a result of the public/private partnership. The changes to the hospital rates represent both increases and decreases depending on the hospital.

Mercer has included an adjustment to the capitation rates to account for the changes to the hospital reimbursement, including the public/private partnership. In order to account for this change, Mercer analyzed the base data by hospital and region separately for adults and children services. For adults, Mercer compared the PIHP fee schedules and per diem costs reported in the encounter data to the new State Medicaid fee schedule. Based on this comparison, Mercer determined no adjustment was needed for the Adult rates as the PIHP fee schedule underlying the encounter data generally aligned with the new State Medicaid fee schedule. For children, however, hospital reimbursement levels in the encounter data generally followed historic State Medicaid fee schedules. As a result, an adjustment was necessary to reflect changes between the historic and the new fee schedule for the children's rates.

Overall, this represents a 0.3% increase to the rate ranges and impacts child rating groups only.

Medication Management Rate Change

Effective January 2013, the prior Medication Management procedure code of 90862 was eliminated and the services were required to be billed under General Evaluation and Management codes 99211-99214, 90863. These codes, as reflected in the base data, were reimbursed at lower rates averaging approximately $47 per unit than the prior medication management services in 2012. The PIHP revised the fee schedule in 2014 to adjust the fees for medication management

services up to prior historical levels. The State indicated it expects providers to continue to be paid at the higher reimbursement level under the Bayou Health program.

Mercer analyzed 2014 encounter data by region and observed an increase in the average reimbursement rate for these services to roughly $73 per unit. Mercer calculated the program change impact based on reported service utilization in each region.

As the Medication Management service costs are captured in both the Medical Physician/Psychiatrist category and the Other Professional category along with other procedures, Mercer calculated a proportionate program change to each category to incorporate the expected impact on the broader service category for this fee increase. Specifically, Mercer applied adjustments to Medical Physician/Psychiatrist and to Other Professional categories of service.

Overall, this represents a 1.4% increase to the rates and impacts all rating groups.

Population Mix Considerations

Disability Medicaid Closure

In 2014, the State eliminated coverage of the Disability Medicaid category identified by Type Case code 125. This group included coverage for approximately 10,000 aged, blind and disabled adults. Although this coverage category was discontinued, approximately 50% of individuals previously eligible are expected to enroll through either provisional Medicaid (Type case 211) or Supplemental Security Income eligibility. Mercer evaluated the historical costs for the Disability Medicaid population identified under Type Case code 125 and compared this group to the remaining population in the Disabled Adult and Dual Eligible Adult rates cells. The Disability Medicaid group had higher-than-average costs in each of the rate cells. Based on the assumption that not all individuals previously covered under Disability Medicaid individuals would reenroll (which is supported by emerging 2014 enrollment), Mercer calculated a downward adjustment to reflect the lower average cost of the remaining population.

LaCHIP – Family and Children

Subsequent to the summarization of the CY 2013 base data, the State informed Mercer of an eligibility group that will be covered under the managed care program for specialized BH services but was not included in the CY 2013 base data. Mercer analyzed historic CY 2013 claim experience for this population group and developed an adjustment factor that reflects the PMPM impact to the existing CY 2013 average PMPM.

The impact of these two population adjustments is a decrease of 0.5% to the rates overall and impacts adult rating groups only.

Retroactive Eligibility Adjustment

The retroactivity considerations for Specialized BH services will mirror the coverage responsibility of the Bayou Health plans for acute care services. As a reminder, beginning in February 2015 members granted retroactive eligibility were capitated retroactively, based on their eligibility for Bayou Health, for up to 12 months prior to enrollment in an MCO. The MCO selected by these members will then receive one capitation payment per month of retroactive enrollment, and will be liable for all claims incurred during this retroactive eligibility period. For Specialized BH services this policy goes into effect on December 1, 2015. Mercer developed an adjustment factor to apply to the base data in the capitation rate development.

The retroactive eligibility adjustment was developed specific to each rate cell as utilization levels for specialized BH services varied between retroactive and non-retroactive enrollees. Retroactive enrollment in any given rate cell will generate the same capitation payment per month to the MCO as any other enrollee in that same rate cell. The factors were developed at a rate cell level on a statewide basis (i.e., all regions used the same factors). The calculation relied upon retroactive claims PMPM, unique enrollee counts, and the average duration to develop the expected increase to Bayou Health claims.

Mercer reviewed the average duration of enrollees who were retroactively enrolled during 2013. The program change was calculated by summarizing the PMPM for the retroactive eligibles and blending it with the respective rate cell PMPM based on enrollment. The program change adjustment reflects the impact on average rate cell PMPMs as a result of adding these retroactive eligibles. The table below summarizes the impact of the Retroactive Eligibility Adjustment.

Population	Adjustment
Non-Disabled Adults	-0.1%
Disabled Adults	0.2%
Non-Disabled Children	-0.2%
Disabled Children	-0.1%
Dually Eligibles	0.0%

Other Populations

The State has outlined recent decisions to further clarity the Bayou Health covered populations for specialized BH services. As these populations represent a change from what was captured in the base data or Data Book, Mercer analyzed the impact on the PMPM for these changes for the final rates. The table below summarized the impact for the following population changes.

- Coverage of Spend-down populations

- Coverage of Medically Needy populations
- Removal of Denied SSI, Forced Benefits and Terminated SSI populations

Population	Adjustment
Non-Disabled Adults	-0.3%
Disabled Adults	-0.0%
Non-Disabled Children	+0.0%
Disabled Children	+0.0%
Dually Eligibles	0.0%

These other population considerations added 23,165 member months (or 0.2%) to the populations included in the Data Book.

Overall, the adjustments for Disability Medicaid Closure, LaCHIP – Family and Child, Retroactive Eligibility and Other Population considerations represent a decrease of 0.6% to the capitation rate ranges on a statewide basis.

Permanent Supportive Housing Provider Rate Increase

Subsequent to CY 2013, the State implemented a 5% rate increase to certain providers delivering community psych services to individuals in the permanent supportive housing (PSH) program. Using the list of PSH providers from the State, Mercer summarized historic cost and utilization data for community psych services for these providers and calculated the impact of the 5% increase. Mercer applied this impact to rating group and region based on historic utilization patterns.

Overall, this represents a 0.1% increase to the rates and impacts all rating groups.

1915(c) CSoC Regional Expansion

As noted earlier in this letter, the CSoC population will be generally excluded from Bayou Health for specialized BH services. Magellan will continue to administer this program. From 2013 through early 2015, the CSoC population has expanded. Mercer evaluated the implications of this expansion on the rate cells for the Bayou Health program.

The State submitted an amendment to the 1915(c) CSoC waiver to increase the number of waiver slots and expand the waiver program statewide starting in 2014. Upon expansion, certain Children previously classified in a disabled or non-disabled rating group shifted to the CSoC program. Mercer calculated the volume of CSoC transitions by comparing the average 2013 CSoC

enrollment to emerging levels as of April, 2015. The growth by region is outlined in the table below:

CSoC Enrollment	Average 2013	As of April, 2015
Gulf	198	449
Capital	214	426
South Central	152	341
North	491	510
Statewide	1,054	1,726

Mercer then analyzed the historic Specialized BH expenses associated with CSoC enrollees and noted that it is materially higher when compared to the PMPM for other child rating groups ($554 PMPM vs $18 PMPM, respectively). Because of this differential, the movement of those higher needs children out of disabled or non-disabled rating groups resulted in a reduction in the average PMPM by region. The transition analysis was performed on a regional basis using the underlying PMPMs for each region as well as CSoC-specific PMPMs for each region.

Overall, this represents a decrease of 1.8% to the rates and impacts child rating groups only.

Bayou Retained Liability for CSoC Specialized BH Services

As individuals change eligibility status between the CSoC program and other Bayou rate cells, the State has implemented policies that warrant program change consideration from the Data Book.

Month One Claim Liability

If individuals transition from a Bayou rate cell to CSoC after the first day of the month, Bayou will retain liability for specialized BH services for the remainder of that month. After the first month of CSoC eligibility, claim liability for specialized BH services will no longer be the responsibility of Bayou. For the capitation rate development, Mercer has assumed full capitation payment for Specialized BH services will be made to the Bayou Health MCOs for the first month for which they are identified for the CSoC waiver, even if the individual is only enrolled in CSoC for a partial month.

To calculate this adjustment, Mercer summarized the initial month of specialized BH services and eligibility for those individuals transitioning to CSoC. Mercer then compared this data to that of non-Disabled and Disabled children to develop an appropriate PMPM adjustment. Because individuals transitioning to CSoC typically have higher utilization levels than that of non-Disabled

or Disabled children, this coverage change results in an upward PMPM adjustment to the costs captured in the Data Book.

SUD Residential/PRTF/TGH Coverage
All SUD Residential, PRTF and TGH services delivered to CSoC individuals will remain with Bayou Health regardless of CSoC eligibility status. Mercer summarized SUD Residential, PRTF and TGH claims for CSoC eligibles and included these expenses in the respective non-Disabled Child or Disabled Child rate cells. This coverage decision results in an upward adjustment to the costs captured in the data book.

The impact of these two considerations is a 0.8% increase to the rates overall and impacts child rating groups only.

Historic Outpatient Cost Settlements
The State has historically implemented fee schedule adjustments for various outpatient services. For outpatient providers, the fee schedule adjustment process includes an estimation of cost settlements that are not captured in the historic base data. Since cost settlements will become the responsibility of the MCOs under managed care, an adjustment to the Bayou Health rates was necessary. Because outpatient services do not constitute a material portion of the service array for Specialized BH, this adjustment was not expected to be material.

To calculate the historic outpatient cost settlement impact, Mercer analyzed provider-level cost settlement information provided by the State. Comparing this information to claim payment data, Mercer calculated the historic cost settlement impact by provider. These cost settlements were included as a program change to the Specialized BH portion of the Bayou Health rates.

Overall, this represents a slight positive impact, rounded to 0.0%, to the rates and impacts all rating groups.

PRTF Per Diem Adjustment
The State informed Mercer of two PRTF providers that have historically been subject to risk sharing arrangements that have had recent per diem changes. The prior risk sharing process resulted in additional payments to the providers as the per diem documented in the cost reports was higher than the interim rates. Mercer has built in consideration of provider specific rates for these providers based on the cost report per diems.

To calculate the impact, the State provided Mercer with the risk sharing calculations that were based on base paid and final targeted per diem rates for these two providers. The final cost

impact was calculated by another firm on behalf of the State. Mercer reviewed these calculations for reasonability but did not audit them. Mercer leveraged the final calculations to determine the net impact to the CY 2013 time period to develop the program change impact. Mercer incorporated the expected cost for the per diem change based on utilization during the 2013 time period and applied an upward adjustment to the PRTF COS.

Overall, this represents an increase 0.2% to the rates on a statewide basis and impacts child rating groups only.

Inpatient Concurrent Review

Based on the contract with the State, Magellan currently authorizes Inpatient stays up to seven day increments, and will be responsible for any current Inpatient authorization period that extends beyond the effective date of December 1, 2105. The Bayou Health MCOs will be responsible for concurrent review of any open authorizations and will assume responsibility for the inpatient stay after the Magellan authorization period ends.

Mercer analyzed the impact of transitioning the responsibility for the concurrent review portion of IP stays that were authorized in the prior month by analyzing 2014 and 2015 claims data. As the Data Book is summarized based on the service begin date for the inpatient stay, this transition of responsibility in the middle of stays that cross-over December 1, 2015 creates an additional liability for the Bayou Health program. This adjustment was applied for one month as only December 2015 will be impacted by the transition from Magellan to Bayou.

Mercer understands that Magellan authorizations are typically seven days. Mercer has assumed any concurrent reviews and continued authorizations by Magellan would occur in seven day increments. As such, Mercer analyzed the average monthly volume of inpatient expenses that start in one month and continue into another month and segmented the stay into a period that concludes Magellan's coverage based on seven day increments with the remainder of the stay transitioning over to Bayou Health. For example, a stay that began on November 14th and continued through December 12th was assumed to be Magellan's responsibility from November 14th through December 5th (first 21 days, 3 7-day increments) with the December 6th through the 12th as the responsibility of the Bayou Health plan.

While this adjustment is only expected to impact the December 2015 coverage month as the average length of stay is approximately 7 days, the adjustment has been scaled to impact half of the rating period of December 2015 and January 2016.

Average monthly expense associated with remainder of stays	$238,000

Average monthly inpatient expense	$5,143,000
Average monthly inpatient impact associated with continuing stays	4.6%
Final impact to the rating period (impact to one of two months only)	2.3%

The table below summarizes the impact by rate cell across all service categories.

Population	Adjustment
Non-Disabled Adults	0.5%
Disabled Adults	1.0%
Non-Disabled Children	0.2%
Disabled Children	0.2%
Dually Eligibles	0.1%

Elimination of the 1915(i) Program Authority and Amendment of the State Plan

In order to accelerate receipt of medically necessary specialized mental health services for adults and make community-based LMHP services available to more individuals, the State intends to transition services currently in the 1915(i) to the Medicaid State Plan. The prior 1915(i) authority limited the availability of certain services to adults requiring acute stabilization or meeting certain functional criteria for a major mental disorder and the seriously mentally ill (SMI). The services covered under the 1915(i) included community psychiatric services including ACT, psychosocial rehab services, and services provided by other licensed mental health professionals. Another aspect of the 1915(i) program was the requirement of an independent assessment to confirm an individual met the population criteria before services could be received.

While the services will be covered under the State Plan, individuals will need to meet medical necessity criteria in order to be authorized for the services. Mercer understands the medical necessity criteria for community psychiatric and psychosocial rehab services will generally align with the diagnosis criteria associated with major mental disorders and SMI. The criteria for other licensed mental health professionals will apply to a broader segment of the covered population and not be specific to major mental disorders or SMI.

Mercer has reviewed the changes to the delivery of these former 1915(i) services with Mercer clinicians and policy consultants and identified two specific rate considerations.

- Elimination of the Independent Assessment will likely result in individuals accessing services more quickly. The State has indicated that individuals have experienced on average a 30-day wait period for services while they await the independent assessment. Mercer analyzed the historical claims data to identify the subset of the 1915(i) users that were new to the program and expected to utilize more services in a 12-month period if the independent assessment was eliminated. Specifically, Mercer evaluated the individuals

who utilized services up through December 2013 and made an assumption about the number of clients who utilized services in December that would have utilized more services had their authorizations started earlier in the year. For example, individuals with 12-months of annual utilization were not impacted by the change, but 87% of the individuals with authorizations starting in December were assumed to use an additional month of service. The summary below shows the program change calculation.

Total 1915(i) recipients in 2013	5,555
Subset of recipients that projected to receive an additional month of service	1,363
Average monthly cost of 1915(i) services	$587
Annualized program change impact	$799,868
Total 2013 1915(i) expenses	$9,753,804

- Expanded access to services provided by other licensed professionals (OLP) will likely result in an increase to the penetration rate over time for other professional services. Individuals will still need to meet medical necessity criteria to access other professional services, but more individuals are expected to meet the criteria than historically when the 1915(i) services were limited to SMI or major mental disorder. To evaluate the potential change in utilization, Mercer reviewed the service utilization and penetration rates for other states where other professional services have been covered in the State Plan. The penetration rates in these other states are higher for adults indicating broader utilization of the services. The penetration rate findings are as follows:

2013 Penetration Rate for OLP Services in Louisiana	2.5% of Adults
Penetration Rate for similar OLP Services in Other States	Up to 10% of Adults

Mercer assumed the utilization of these services would increase over time essentially modeling a two-fold expansion of these services from November 2015 to January 2017. The utilization has been assumed to progressively increase over time as provider capacity may need to be developed to meet the demand as individuals understand the availability of these services.

Projected November 2015 users based on emerging data	3,549
Projected January 2017 users	7,097
Total new users in rating period for December 2015 and January 2016	760
Average monthly cost of services provided by other licensed professionals	$82

Annualized program change impact ($62,455 multiplied by 6)	$374,733
Total 2013 services provided by other licensed professionals	$6,563,731

This issue will continue to be monitored and evaluated as part of future rate-setting exercises as more data becomes available. The overall impact of the adjustment to account for the elimination of the 1915(i) authority and coverage of these services under the State Plan is a 0.6% impact overall and impacts the adult rate cells only.

The overall impact all of all the programmatic changes described above is a 1.3% increase to the rates. Again, the regional and rate cell impacts of these changes are summarized in Appendix C.

1915(b)(3) Services

The historical utilization of Physician Case Consultation services has been minimal in the initial years of the program. As such, the 1915(b)(3) rate for this service is essentially $0.00 on a PMPM basis. The service utilization will continue to be analyzed and the rate adjusted accordingly, as necessary. This is within the requested waiver authority of $0.13 PMPM.

Managed Care Assumptions

Mercer evaluated whether additional adjustments were necessary to address changes to utilization as a result of care management practices. As the adult encounter data are from a period of time when capitated managed care was in operation, Mercer did not incorporate any further adjustment for future changes as a result of managed care. Similarly, Mercer made no adjustment to the Children's capitation rate calculations for additional impact of managed care. While the data from the Children's program are from a non-risk setting, the current PIHP did perform utilization review and care management of the Children's population under the non-risk contract. Also, the two-month rating period of December/January does not provide sufficient time to impact the service utilization patterns.

Administration and Risk Margin Loading

Mercer included an assumption for administrative expenses under a managed care program with particular consideration for the impact of integration with the existing Bayou Health acute care program. The State provided Mercer with anticipated staffing requirements for the upcoming Bayou Health contract period beginning December 1, 2015. Mercer reviewed the behavioral health staffing requirements as they apply to each MCO participating in the Bayou Health program. Each staffing position was evaluated to determine if it would be already fulfilled within the current Bayou health program, and therefore would not need to be considered as part of the behavioral health program. The administrative costs for the required staffing positions were

modeled based on wage and other employee-related expense information from the Bureau of Labor and Statistics. Mercer also included consideration for MCO overhead for these staffing positions. Mercer developed a PMPM cost expectation for these additional staffing needs and converted the PMPM to a percentage based on the final service cost projection underlying the rates.

Based on this review, Mercer included a general administrative allowance of 8.0%, which is similar to the prior administrative assumption under the current adult capitation rates. This is due to the fact that the State is now contracting with multiple MCOs rather than just one. In addition to the general administrative allowance, an underwriting gain/risk margin of 2.0% has been included in the capitation rates. The administration and risk margin load factor (AA.3.2) is expressed as a percentage of the gross capitation rate (that is, premium) before premium tax adjustment, and is consistent with the current Bayou Health rates.

Health Insurer Provider Fee Consideration

The State plans to address the Health Insurer Provider Fee and associated implications of non-deductibility through a retrospective payment once the fees are known for the impacted premium years. As such, no consideration has been made for the fee in these capitation rates. Further discussion between the MCOs and the State will occur as fee notices become available from the IRS for the respective premium year.

Premium Tax Adjustment

Louisiana Statute 22:842 requires businesses issuing life, accident, health or service insurance or other forms of contracts or obligations covering such risks to pay certain premium taxes. The tax for businesses with revenue exceeding $7,000 amounts to 2.25% of gross annual premiums. The State has determined that the PIHP contract for the Medicaid Adult capitated BH program is subject to this taxation. This is a uniform, broad-based fee imposed on all health maintenance organizations and preferred provider organizations and all lines of business.

This premium tax is a legitimate cost of doing business in the State of Louisiana for Medicaid managed care organizations and PIHPs, and reasonable to include in the consideration of actuarially sound capitation rate ranges. Since this is a cost of doing business in the State, Mercer included consideration for this tax in the rate range development.

The premium tax adjustment is expressed as a percentage of the gross capitation rate (that is, premium). Mercer applied a 2.25% upward adjustment to the rate to account for the premium tax.

Rate Ranges

In order to develop the rate ranges, Mercer varied the trend assumptions outlined above to reflect the potential fluctuations in service utilization growth beyond observed experience. The lower bound trend accounts for mitigation of trend from the observed early 2015 levels, whereas the upper bound reflects higher consideration of trends from 2015 Mercer recognizes that prospective trends can vary based, not only on fluctuations in service utilization but also on the achieved degree of care management. Variation in these trend assumptions results in a rate range of approximately 5.9% below the 50th %-ile rate for the Lower Bound and 5.9% above the 50th %-ile rate for the Upper Bound.

The rate ranges can be found on Appendix B.

Rate Development Overview

To provide additional detail on the rate development, Mercer has provided an overview of the adjustments applied to each rate cell in Appendices B and C. The exhibits present the breakdown of the assumptions used to calculate the 50th %-ile rates within the actuarially sound rate ranges for each region.

Rate Certification

In preparing the rate ranges shown in Appendix B for the December 1, 2015 through January 31, 2016 contract period for the Louisiana BH program, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design, and financial data and information supplied by the State and the PIHP. The State and the PIHP are solely responsible for the validity and completeness of these supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion they are appropriate for the intended rate-setting purpose. However, if the data and information are incomplete and/or inaccurate, the values shown in this report may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this report.

Because modeling all aspects of a situation or scenario is not possible or practical, Mercer may use summary information, estimates, or simplifications of calculations to facilitate the modeling of future events in an efficient and cost-effective manner. Mercer may also exclude factors or data that are immaterial in our judgment. Use of such simplifying techniques does not, in our judgment, affect the reasonableness, appropriateness, or attainability of the results for the Medicaid program. Actuarial assumptions may also be changed from one certification period to the next because of changes in mandated requirements, program experience, changes in expectations

about the future, and other factors. A change in assumptions is not an indication that prior assumptions were unreasonable, inappropriate, or unattainable when they were made.

Mercer certifies that the rate ranges in Appendix B, were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid-covered populations and services under the managed care contract. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rate ranges developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time, and are subject to unforeseen and random events. Therefore any projection must be interpreted as having a likely, and potentially wide range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual MCO costs will differ from these projections. Mercer has developed these rate ranges on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

MCOs are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges by the MCOs for any purpose. Mercer recommends that the MCOs analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rate ranges before deciding whether to contract with the State.

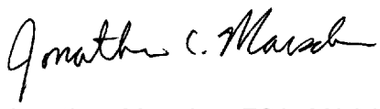
The State understands that Mercer is not engaged in the practice of law, or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends that the State secures the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

This certification letter assumes the reader is familiar with the Louisiana managed care program, Medicaid eligibility rules and actuarial rating techniques. It is intended for the State and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results. This document should only be reviewed in its entirety. Mercer is not responsible for, and expressly disclaims liability for, any reliance on this report by third parties.

The State agrees to notify Mercer within 30 days of receipt of this report if it disagrees with anything contained in this report or is aware of any information or data that would affect the results of this report that has not been communicated or provided to Mercer or incorporated herein. The report will be deemed final and acceptable to the State if nothing is received by Mercer within such 30-day period.

If you have any questions on any of the information provided, please feel free to call me at 612 642 8940, Brad at 612 642 8756 or Bennett at 612 642 8609.

Sincerely,



Jonathan Marsden, FSA, MAAA
Partner



Brad Diaz, FSA, MAAA
Senior Associate



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Senior Associate

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Appendices

Appendix A
Louisiana Behavioral Health Partnership Medicaid Capitation Rates
Effective December 1, 2015 to January 31, 2016
50th Percentile Rates by Rate Cell and Region for Specialized BH Services

MARSH & McLENNAN COMPANIES

50th Percentile Rates by Rate Cell and Region
December 1, 2015 - January 31, 2016

		Contract Period December 1, 2015 - January 31, 2016			
Rate Cell	Age	Gulf Region	Capital Region	South Central Region	North Region
Non-Disabled Adults	21+	$ 29.26	$ 25.76	$ 25.91	$ 28.76
Disabled Adults	21+	$ 104.37	$ 84.66	$ 84.27	$ 75.27
Non-Disabled Children	0-20	$ 28.52	$ 28.14	$ 23.58	$ 40.90
Foster Care and Disabled Children	0-20	$ 170.07	$ 139.10	$ 152.44	$ 246.19
Dually Eligible	Any	$ 18.50	$ 6.78	$ 7.49	$ 8.84

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Appendices

Appendix B
Louisiana Behavioral Health Partnership Medicaid Capitation Rate Development
Effective December 1, 2015 to January 31, 2016
Adult and Child Rate Cells

MARSH & McLENNAN COMPANIES

Rate Development Summary
December 1, 2015 - January 31, 2016

Gulf Region		Base Year		Rate Development Data Adjustments				Rate Development Loads			Contract Period December 1, 2015 - January 31, 2016		
		A	B	C	D	E	F	G	H	I			
Rate Cell	Age	MMs	PMPM	Trend *	Program Changes	Managed Care Adjustment	Target Service Cost	Underwriting Gain **	Administration **	Premium Tax **	50th Percentile Rate ***	Lower Bound Rate	Upper Bound Rate
Non-Disabled Adults	21+	386,912	$ 13.85	25.9%	4.6%	0.0%	$ 25.72	2.0%	8.0%	2.25%	$ 29.26	$ 27.57	$ 30.95
Disabled Adults	21+	305,452	$ 66.79	11.1%	5.8%	0.0%	$ 91.76	2.0%	8.0%	2.25%	$ 104.37	$ 99.78	$ 108.97
Non-Disabled Children	0-20	2,248,412	$ 12.98	30.3%	-0.3%	0.0%	$ 25.02	2.0%	8.0%	2.25%	$ 28.52	$ 26.66	$ 30.38
Foster Care and Disabled Children	0-20	186,151	$ 74.76	32.2%	-0.4%	0.0%	$ 149.20	2.0%	8.0%	2.25%	$ 170.07	$ 159.24	$ 180.91
Dually Eligible	Any	275,235	$ 9.17	22.7%	6.3%	0.0%	$ 16.26	2.0%	8.0%	2.25%	$ 18.50	$ 17.45	$ 19.55
Total		**3,402,162**	**$ 20.88**	**25.3%**	**1.6%**	**0.0%**	**$ 37.18**	**2.0%**	**8.0%**	**2.25%**	**$ 42.35**	**$ 39.84**	**$ 44.86**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

** Admin & Underwriting Gain shown as a % of the total rate before premium tax. Premium Tax is shown as a percent of total premium.

*** Rate Development Formula: 50th Percentile Rate = [B*(1+C)^(30/12)*(1+D)*(1+E)]/(1-G-H)/(1-I)

Rate Development Summary
December 1, 2015 - January 31, 2016

Capital Region		Base Year		Rate Development Data Adjustments				Rate Development Loads			Contract Period December 1, 2015 - January 31, 2016		
		A	B	C	D	E	F	G	H	I			
Rate Cell	Age	MMs	PMPM	Trend *	Program Changes	Managed Care Adjustment	Target Service Cost	Underwriting Gain **	Administration **	Premium Tax **	50th Percentile Rate ***	Lower Bound Rate	Upper Bound Rate
Non-Disabled Adults	21+	282,441	$ 14.29	18.1%	4.6%	0.0%	$ 22.65	2.0%	8.0%	2.25%	$ 25.76	$ 24.56	$ 26.96
Disabled Adults	21+	239,540	$ 60.83	7.7%	1.8%	0.0%	$ 74.44	2.0%	8.0%	2.25%	$ 84.66	$ 81.66	$ 87.66
Non-Disabled Children	0-20	2,028,943	$ 12.18	31.9%	1.8%	0.0%	$ 24.72	2.0%	8.0%	2.25%	$ 28.14	$ 26.36	$ 29.91
Foster Care and Disabled Children	0-20	159,015	$ 60.36	31.2%	2.8%	0.0%	$ 122.25	2.0%	8.0%	2.25%	$ 139.10	$ 130.65	$ 147.55
Dually Eligible	Any	222,400	$ 3.17	26.9%	3.8%	0.0%	$ 5.96	2.0%	8.0%	2.25%	$ 6.78	$ 6.46	$ 7.11
Total		**2,932,339**	**$ 18.29**	**24.7%**	**2.2%**	**0.0%**	**$ 32.45**	**2.0%**	**8.0%**	**2.25%**	**$ 36.92**	**$ 34.85**	**$ 38.99**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

** Admin & Underwriting Gain shown as a % of the total rate before premium tax. Premium Tax is shown as a percent of total premium.

*** Rate Development Formula: 50th Percentile Rate = [B*(1+C)^(30/12)*(1+D)*(1+E)]/(1-G-H)/(1-I)

Rate Development Summary
December 1, 2015 - January 31, 2016

South Central Region		Base Year		Rate Development Data Adjustments				Rate Development Loads			Contract Period December 1, 2015 - January 31, 2016		
		A	B	C	D	E	F	G	H	I			
Rate Cell	Age	MMs	PMPM	Trend *	Program Changes	Managed Care Adjustment	Target Service Cost	Underwriting Gain **	Administration **	Premium Tax **	50th Percentile Rate ***	Lower Bound Rate	Upper Bound Rate
Non-Disabled Adults	21+	295,987	$ 15.38	15.4%	3.7%	0.0%	$ 22.77	2.0%	8.0%	2.25%	$ 25.91	$ 24.53	$ 27.28
Disabled Adults	21+	282,541	$ 67.29	4.2%	-0.5%	0.0%	$ 74.09	2.0%	8.0%	2.25%	$ 84.27	$ 81.00	$ 87.54
Non-Disabled Children	0-20	2,220,847	$ 10.68	32.0%	-2.9%	0.0%	$ 20.69	2.0%	8.0%	2.25%	$ 23.58	$ 22.16	$ 25.01
Foster Care and Disabled Children	0-20	171,952	$ 70.60	29.5%	-0.4%	0.0%	$ 133.69	2.0%	8.0%	2.25%	$ 152.44	$ 142.86	$ 162.03
Dually Eligible	Any	296,258	$ 5.00	11.7%	-0.1%	0.0%	$ 6.59	2.0%	8.0%	2.25%	$ 7.49	$ 7.09	$ 7.89
Total		**3,267,585**	**$ 18.64**	**22.0%**	**-1.3%**	**0.0%**	**$ 30.16**	**2.0%**	**8.0%**	**2.25%**	**$ 34.36**	**$ 32.45**	**$ 36.28**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

** Admin & Underwriting Gain shown as a % of the total rate before premium tax. Premium Tax is shown as a percent of total premium.

*** Rate Development Formula: 50th Percentile Rate = [B*(1+C)^(30/12)*(1+D)*(1+E)]/(1-G-H)/(1-I)

Rate Development Summary
December 1, 2015 - January 31, 2016

North Region		Base Year		Rate Development Data Adjustments				Rate Development Loads			Contract Period December 1, 2015 - January 31, 2016		
		A	B	C	D	E	F	G	H	I			
Rate Cell	Age	MMs	PMPM	Trend *	Program Changes	Managed Care Adjustment	Target Service Cost	Underwriting Gain **	Administration **	Premium Tax **	50th Percentile Rate ***	Lower Bound Rate	Upper Bound Rate
Non-Disabled Adults	21+	223,944	$ 15.62	19.2%	4.4%	0.0%	$ 25.27	2.0%	8.0%	2.25%	$ 28.76	$ 27.15	$ 30.37
Disabled Adults	21+	239,483	$ 47.21	13.2%	2.8%	0.0%	$ 66.16	2.0%	8.0%	2.25%	$ 75.27	$ 71.65	$ 78.89
Non-Disabled Children	0-20	1,731,176	$ 16.87	34.6%	1.4%	0.0%	$ 35.34	2.0%	8.0%	2.25%	$ 40.90	$ 38.08	$ 43.71
Foster Care and Disabled Children	0-20	158,711	$ 134.32	19.3%	3.8%	0.0%	$ 213.36	2.0%	8.0%	2.25%	$ 246.19	$ 230.17	$ 262.21
Dually Eligible	Any	232,802	$ 3.99	27.6%	5.9%	0.0%	$ 7.77	2.0%	8.0%	2.25%	$ 8.84	$ 8.27	$ 9.41
Total		**2,586,116**	**$ 25.62**	**25.6%**	**2.5%**	**0.0%**	**$ 45.76**	**2.0%**	**8.0%**	**2.25%**	**$ 52.74**	**$ 49.35**	**$ 56.14**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

** Admin & Underwriting Gain shown as a % of the total rate before premium tax. Premium Tax is shown as a percent of total premium.

*** Rate Development Formula: 50th Percentile Rate = [B*(1+C)^(30/12)*(1+D)*(1+E)]/(1-G-H)/(1-I)

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Appendices

Appendix C
Program Change Calculations
Effective December 1, 2015 to January 31, 2016

MARSH & McLENNAN COMPANIES

Program Changes - Impact Summary
December 1, 2015 - January 31, 2016

Gulf Region		Individual Program Changes - PMPM Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	$ 24.60	$ 0.10	$ -	$ 0.44	$ (0.10)	$ 0.01	$ -	$ -	$ 0.00	$ -	$ 0.67	$ 1.12
Disabled Adults	21+	$ 86.76	$ 0.73	$ -	$ 1.75	$ 0.34	$ 0.22	$ -	$ -	$ (0.01)	$ -	$ 1.97	$ 5.00
Non-Disabled Children	0-20	$ 25.08	$ 0.04	$ 0.07	$ 0.30	$ (0.09)	$ 0.01	$ (0.69)	$ 0.27	$ 0.00	$ 0.02	$ -	$ (0.06)
Foster Care and Disabled Children	0-20	$ 149.78	$ 0.27	$ 0.30	$ 2.29	$ (0.12)	$ 0.13	$ (5.15)	$ 1.11	$ 0.01	$ 0.58	$ -	$ (0.59)
Dually Eligible	Any	$ 15.30	$ 0.01	$ -	$ 0.01	$ 0.24	$ 0.08	$ -	$ -	$ 0.00	$ -	$ 0.61	$ 0.96
Total		**$ 36.60**	**$ 0.12**	**$ 0.06**	**$ 0.53**	**$ (0.03)**	**$ 0.04**	**$ (0.74)**	**$ 0.24**	**$ 0.00**	**$ 0.04**	**$ 0.30**	**$ 0.58**

		Individual Program Changes - Percent Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	n/a	0.4%	0.0%	1.8%	-0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	2.7%	4.6%
Disabled Adults	21+	n/a	0.8%	0.0%	2.0%	0.4%	0.2%	0.0%	0.0%	0.0%	0.0%	2.3%	5.8%
Non-Disabled Children	0-20	n/a	0.2%	0.3%	1.2%	-0.4%	0.1%	-2.8%	1.1%	0.0%	0.1%	0.0%	-0.3%
Foster Care and Disabled Children	0-20	n/a	0.2%	0.2%	1.5%	-0.1%	0.1%	-3.4%	0.7%	0.0%	0.4%	0.0%	-0.4%
Dually Eligible	Any	n/a	0.1%	0.0%	0.1%	1.6%	0.6%	0.0%	0.0%	0.0%	0.0%	4.0%	6.3%
Total		**n/a**	**0.3%**	**0.2%**	**1.5%**	**-0.1%**	**0.1%**	**-2.0%**	**0.7%**	**0.0%**	**0.1%**	**0.8%**	**1.6%**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

Program Changes - Impact Summary
December 1, 2015 - January 31, 2016

Capital Region		Individual Program Changes - PMPM Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	$ 21.64	$ 0.15	$ -	$ 0.50	$ (0.09)	$ 0.00	$ -	$ -	$ 0.10	$ 0.00	$ 0.35	$ 1.00
Disabled Adults	21+	$ 73.13	$ 0.82	$ -	$ 1.71	$ (2.66)	$ 0.01	$ -	$ 0.00	$ 0.25	$ -	$ 1.20	$ 1.31
Non-Disabled Children	0-20	$ 24.29	$ 0.05	$ 0.40	$ 0.60	$ (0.01)	$ 0.00	$ (0.94)	$ 0.28	$ 0.02	$ 0.04	$ -	$ 0.44
Foster Care and Disabled Children	0-20	$ 118.88	$ 0.30	$ 2.57	$ 2.73	$ (0.09)	$ 0.06	$ (5.96)	$ 2.93	$ 0.09	$ 0.74	$ -	$ 3.37
Dually Eligible	Any	$ 5.74	$ 0.01	$ -	$ 0.04	$ 0.02	$ 0.01	$ -	$ -	$ 0.00	$ -	$ 0.15	$ 0.22
Total		**$ 31.75**	**$ 0.13**	**$ 0.41**	**$ 0.75**	**$ (0.24)**	**$ 0.01**	**$ (0.98)**	**$ 0.35**	**$ 0.05**	**$ 0.07**	**$ 0.14**	**$ 0.71**

		Individual Program Changes - Percent Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	n/a	0.7%	0.0%	2.3%	-0.4%	0.0%	0.0%	0.0%	0.4%	0.0%	1.6%	4.6%
Disabled Adults	21+	n/a	1.1%	0.0%	2.3%	-3.6%	0.0%	0.0%	0.0%	0.3%	0.0%	1.6%	1.8%
Non-Disabled Children	0-20	n/a	0.2%	1.6%	2.5%	0.0%	0.0%	-3.9%	1.1%	0.1%	0.2%	0.0%	1.8%
Foster Care and Disabled Children	0-20	n/a	0.2%	2.2%	2.3%	-0.1%	0.0%	-5.0%	2.5%	0.1%	0.6%	0.0%	2.8%
Dually Eligible	Any	n/a	0.1%	0.0%	0.6%	0.3%	0.1%	0.0%	0.0%	0.1%	0.0%	2.5%	3.8%
Total		**n/a**	**0.4%**	**1.3%**	**2.4%**	**-0.7%**	**0.0%**	**-3.1%**	**1.1%**	**0.2%**	**0.2%**	**0.5%**	**2.2%**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

South Central Region		Individual Program Changes - PMPM Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	$ 21.96	$ 0.14	$ -	$ 0.37	$ (0.09)	$ 0.01	$ -	$ -	$ (0.00)	$ -	$ 0.39	$ 0.82
Disabled Adults	21+	$ 74.47	$ 0.84	$ -	$ 1.14	$ (3.47)	$ 0.08	$ -	$ -	$ (0.00)	$ -	$ 1.04	$ (0.37)
Non-Disabled Children	0-20	$ 21.30	$ 0.04	$ 0.01	$ 0.08	$ (0.08)	$ 0.00	$ (0.76)	$ 0.07	$ 0.00	$ 0.03	$ -	$ (0.61)
Foster Care and Disabled Children	0-20	$ 134.24	$ 0.30	$ (0.07)	$ 0.56	$ (0.11)	$ 0.01	$ (3.70)	$ 1.36	$ 0.00	$ 1.10	$ -	$ (0.55)
Dually Eligible	Any	$ 6.59	$ 0.01	$ -	$ 0.01	$ (0.18)	$ 0.01	$ -	$ -	$ 0.01	$ -	$ 0.13	$ (0.01)
Total		**$ 30.57**	**$ 0.13**	**$ 0.00**	**$ 0.22**	**$ (0.39)**	**$ 0.01**	**$ (0.71)**	**$ 0.12**	**$ 0.00**	**$ 0.08**	**$ 0.14**	**$ (0.40)**

		Individual Program Changes - Percent Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	n/a	0.6%	0.0%	1.7%	-0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	3.7%
Disabled Adults	21+	n/a	1.1%	0.0%	1.5%	-4.7%	0.1%	0.0%	0.0%	0.0%	0.0%	1.4%	-0.5%
Non-Disabled Children	0-20	n/a	0.2%	0.0%	0.4%	-0.4%	0.0%	-3.6%	0.3%	0.0%	0.2%	0.0%	-2.9%
Foster Care and Disabled Children	0-20	n/a	0.2%	-0.1%	0.4%	-0.1%	0.0%	-2.8%	1.0%	0.0%	0.8%	0.0%	-0.4%
Dually Eligible	Any	n/a	0.2%	0.0%	0.1%	-2.7%	0.2%	0.0%	0.0%	0.1%	0.0%	2.0%	-0.1%
Total		**n/a**	**0.4%**	**0.0%**	**0.7%**	**-1.3%**	**0.0%**	**-2.3%**	**0.4%**	**0.0%**	**0.3%**	**0.4%**	**-1.3%**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

North Region		Individual Program Changes - PMPM Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	$ 24.20	$ 0.12	$ -	$ 0.46	$ (0.10)	$ 0.00	$ -	$ -	$ (0.03)	$ -	$ 0.63	$ 1.07
Disabled Adults	21+	$ 64.34	$ 0.55	$ -	$ 1.43	$ (1.40)	$ 0.04	$ -	$ -	$ (0.32)	$ -	$ 1.52	$ 1.82
Non-Disabled Children	0-20	$ 34.86	$ 0.06	$ (0.01)	$ 0.25	$ (0.05)	$ 0.01	$ (0.09)	$ 0.30	$ (0.01)	$ 0.01	$ -	$ 0.48
Foster Care and Disabled Children	0-20	$ 205.64	$ 0.42	$ (0.20)	$ 1.46	$ (0.16)	$ 0.03	$ (0.34)	$ 4.32	$ (0.11)	$ 2.30	$ -	$ 7.71
Dually Eligible	Any	$ 7.33	$ 0.02	$ -	$ 0.03	$ 0.08	$ 0.02	$ -	$ -	$ 0.01	$ -	$ 0.27	$ 0.44
Total		**$ 44.67**	**$ 0.13**	**$ (0.02)**	**$ 0.43**	**$ (0.17)**	**$ 0.02**	**$ (0.08)**	**$ 0.47**	**$ (0.04)**	**$ 0.15**	**$ 0.22**	**$ 1.10**

		Individual Program Changes - Percent Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	n/a	0.5%	0.0%	1.9%	-0.4%	0.0%	0.0%	0.0%	-0.1%	0.0%	2.6%	4.4%
Disabled Adults	21+	n/a	0.9%	0.0%	2.2%	-2.2%	0.1%	0.0%	0.0%	-0.5%	0.0%	2.4%	2.8%
Non-Disabled Children	0-20	n/a	0.2%	0.0%	0.7%	-0.1%	0.0%	-0.3%	0.9%	0.0%	0.0%	0.0%	1.4%
Foster Care and Disabled Children	0-20	n/a	0.2%	-0.1%	0.7%	-0.1%	0.0%	-0.2%	2.1%	-0.1%	1.1%	0.0%	3.8%
Dually Eligible	Any	n/a	0.2%	0.0%	0.5%	1.1%	0.2%	0.0%	0.0%	0.2%	0.0%	3.7%	5.9%
Total		**n/a**	**0.3%**	**0.0%**	**1.0%**	**-0.4%**	**0.0%**	**-0.2%**	**1.0%**	**-0.1%**	**0.3%**	**0.5%**	**2.5%**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

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Appendices

Appendix D
CMS Consultation Guide
Effective December 1, 2015 to January 31, 2016

Section I. December 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
1. General Information	
A. A letter from the certifying actuary, who meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board, that certifies that the final capitation rates or rate ranges meet the standards in 42 CFR §438.6(c).	Please refer to the Mercer rate certification letter. All following page and exhibit references are specific to this certification.
B. The final and certified capitation rates or the final and certified rate ranges for all rate cells and regions, as applicable.	Please refer to Appendix B for a summary of all rate ranges by rate cell and region.
C. Brief descriptions of:	
i. The specific state Medicaid managed care programs covered by the certification.	Please refer to pages 1-2.
ii. The rating periods covered by the certification.	Please refer to page 1.
iii. The Medicaid populations covered through the managed care programs for which the certification applies.	A brief description can be found on pages 2-3. Section 2 of the Data Book encompasses a comprehensive list of Bayou Health's covered and excluded populations.
iv. The services that are required to be provided by the managed care plans.	A brief description can be found on pages 3-4. Section 3 of the Data Book encompasses a comprehensive list of Bayou Health's covered services.
2. Data	
A. A description of the data used to develop capitation rates. This description should include:	
i. The types of data used, which may include (but is not limited to) claims data, encounter data, plan financial data, or other Medicaid program data.	Please refer to pages 4-9.
ii. The age of all data used.	Please refer to pages 4-9.
iii. The sources of all data used.	Please refer to pages 4-9.
iv. To the extent that a significant portion of benefits are provided through subcapitated arrangements, a description of the data received from the subcapitated plans or providers.	N/A

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Section I. December 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
v. To the extent that claims or encounter data are not used or not available, an explanation of why that data was not used or was not available.	N/A
B. Information related to the availability and the quality of the data used:	
i. The steps taken by the actuary or by others (which may include but is not limited to the state Medicaid program or the managed care organizations) to validate or improve the quality and accuracy of the data.	Please refer to the base data adjustment section beginning on page 6.
ii. Any concerns that the actuary has over the availability or quality of the data.	N/A
C. Any information related to changes in data used when compared to the most recent rating period:	
i. Any new data sources used by the actuary since the last certification and any data sources that the actuary has not continued to use since the last certification.	The Children's program has been administered on a non-risk basis by the PIHP. This data was not included in the prior LBHP certification for the Adult population at-risk capitation contract.
ii. How the data sources used have changed since the last certification.	Please refer to the base data adjustment section beginning on page 6.
D. Any plans or efforts to improve the data sources used for future certifications and any new data sources that are expected to be available and potentially used for future certifications.	Please refer to the base data adjustment section beginning on page 6.
E. Any adjustments that are made to the data.	Please refer to the base data adjustment section beginning on page 6.
3. Projected Benefit Costs	
A. Covered services and benefits	
i. Any changes related to the benefits covered by the Medicaid managed care organizations since the last certification, including but not limited to:	
a. More or fewer state plan benefits covered by the Medicaid managed care organization.	Please refer to the covered services section on pages 3-4.

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Section I. December 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
b. Requirements deemed necessary by the state to ensure access or proper delivery of covered services, for minimum or maximum levels of payment from managed care organizations to any providers or class of providers.	Please refer to the covered services section on pages 3-4, as well as the base data adjustments section on pages 6-8.
c. Requirements or conditions of any applicable waivers.	N/A
ii. For each change related to benefits covered, the estimated impact of the change on amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment.	Please refer to the covered services section on pages 3-4, as well as the base data adjustments section on pages 6-8. Section 4 of the Data Book outlines adjustments Mercer made to the encounter data and the impacts of each adjustment.
B. Projected benefit cost trends	
i. The projected change in benefit costs from the historical period to the rating period, or trend, including but not limited to:	
a. The methodologies used to develop projected benefit costs trends.	Please refer to the trend section beginning on page 8.
b. Any data used or assumptions made in developing projected benefit cost trends.	Please refer to the trend section beginning on page 8.
c. Any applicable comparisons to historical benefit cost trends or other program benefit cost trends.	Please refer to the trend section beginning on page 8.
d. The different components of projected benefit cost trends, including but not limited to changes in price (such as provider reimbursement rates) and changes in utilization (such as the volume of services provided).	Please refer to the trend section beginning on page 8.
e. Any other material adjustments to projected benefit cost trends, and a description of the data, assumptions, and methodologies used to determine those adjustments.	N/A
f. To the extent there are any differences, projected benefit cost trends by:	
i. Service or category of service.	Please refer to the trend section beginning on page 8.
ii. Rate cell or Medicaid population.	Please refer to the trend section beginning on page 8.

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Section I. December 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
C. Other adjustments to projected benefit costs:	
i. Any other adjustments made to projected benefit costs excluding those described above, including but not limited to:	
a. The impact of managed care on the utilization on the unit costs of health care services.	Please refer to the managed care assumptions section on page 22.
b. Changes to projected benefit costs in the rating period outside of regular changes in utilization or unit cost of services.	Please refer to the program changes section beginning on page 13.
D. Final projected benefit costs by relevant level of detail (for example, by Medicaid population or by rate cell).	Please refer to Appendices A and B.
4. Projected Non-benefit Costs	
E. Non-benefit costs including but not limited to:	
i. Administrative costs.	Please refer to the administration and risk margin loading section beginning on page 22.
ii. Care management or coordination costs.	Included as a component of Administrative costs. Please refer to the administration and risk margin loading section beginning on page 22.
iii. Provisions for:	
a. Cost of capital.	Please refer to the administration and risk margin loading section beginning on page 22.
b. Risk margin.	Considered in the Margin component. Please refer to the administration and risk margin loading section beginning on page 22.
c. Contingency margin.	N/A
d. Underwriting gain.	Included as a component of Administrative costs. Please refer to the administration and risk margin loading section beginning on page 22.
e. Profit margin.	N/A
iv. Taxes, fees, and assessments.	Please refer to the health insurer provider fee consideration and premium tax adjustment sections beginning on page 23.
v. Any other material non-benefit costs.	N/A
5. Rate Range Development	
A. Any assumptions for which values vary in order to develop rate ranges.	Please refer to the trend section beginning on page 8, the administration and risk margin loading section beginning on page 22 and the rate ranges section on page 24.

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Section I. December 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
B. The values of each of the assumptions used to develop the minimum, the mid-point (as applicable), and the maximum of the rate ranges.	Please refer to sections related to trend assumptions, prospective program change adjustments, administration and risk margin loading considerations and rate range assumptions.
C. A description of the data, assumptions, and methodologies that were used to develop the values of the assumptions for the minimum, the mid-point (as applicable), and maximum of the rate ranges.	Please refer to sections related to trend assumptions, prospective program change adjustments, administration and risk margin loading considerations and rate range assumptions.
6. Risk and Contractual Provisions	
A. Risk adjustment processes.	Please refer to the administration and risk margin loading section beginning on page 22.
B. Risk sharing arrangements, such as risk corridor or large claims pool.	N/A
C. Medical loss ratio requirements, such as a minimum medical loss ratio requirement.	N/A
D. Reinsurance requirements.	N/A
E. Incentives or withhold amounts.	N/A
7. Other Rate Development Considerations	
A. All adjustments to the capitation rates, or to any portion of the capitation rates, should reflect reasonable, appropriate, and attainable costs in the actuary's opinion and must be included in the rate certification. CMS notes that adjustments that are performed at the end of the rate setting process without adequate justification might not be considered actuarially sound.	Please see Actuarial soundness definition on page 1, as well as the rate certification section on pages 24-26.
B. The final contracted rates should either match the capitation rates or be within the rate ranges in the actuarial certification. This is required in total and by each rate cell.	This letter certifies the rate range. Rates are being set at the 50th percentile for all rating categories and illustrated on Appendices A and B.

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November 4, 2015

Subject: Louisiana Bayou Health Non-Emergency Medical Transportation (NEMT) Services – Full Risk-Bearing Managed Care Organization (MCO) Rate Range Development and Actuarial Certification for the Period December 1, 2015 through January 31, 2016

Dear Ms. Steele:

The Louisiana Department of Health and Hospitals (DHH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for NEMT services provided under the State of Louisiana's Bayou Health program. NEMT capitation rate ranges were developed for the period December 1, 2015 through January 31, 2016. These rates were developed for individuals that received specialized behavioral health services under the Bayou Health program, but received physical health services under Louisiana fee-for-service (FFS) Medicaid. This population was classified into the following rate cells: Chisholm Class Members (CCM), Home- and Community-Based Services (HCBS) Waiver members, and Other. The Other rate cell is constructed of dually eligible individuals and Long-Term Services and Support (LTSS) recipients who are not in either of the other two NEMT rate cells. This letter provides an overview of the analyses and methodology used in the development of the NEMT rate ranges, as well as a certification to the actuarial soundness of the rate ranges presented.

Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government mandated assessments, fees, and taxes, and the cost of capital. Note: Please see pages 8-9 of the August 2005, Actuarial Certification of Rates for Medicaid Managed Care Programs, from the American Academy of Actuaries, http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.

Rate Methodology

Overview

NEMT capitation rate ranges were developed in accordance with rate-setting guidelines established by the Centers for Medicare & Medicaid Services (CMS). Calendar year (CY) 2013 FFS data with runout through March 31, 2015 were used as the base data for December 1, 2015 through January 31, 2016 NEMT rate development.

Mercer applied the following additional adjustments to the base data, which are consistent with the CMS capitated rate-setting checklist:

- Trend factors to forecast expenditures and utilization to the contract period.
- Loading for non-medical expenses.

The various steps used in the development of the rate ranges are described in the following paragraphs.

NEMT Rate Development

Covered Populations

Mercer received eligibility and enrollment data from the State's fiscal agent. The covered populations under the NEMT rate include the Medicaid eligible population excluded from Bayou Health physical health services and the Voluntary Opt-In populations who have not chosen to enroll in Bayou Health physical health services. The excluded populations primarily include dually eligible individuals and nursing facility residents. Mercer assigned rate cells using the following hierarchy:

1. CCM
2. HCBS Waiver Recipients
3. Other

CCM

Chisholm refers to a class action lawsuit (*Chisholm v. Hood*) filed in 1997. CCMs are defined as all current and future recipients of Medicaid in the State of Louisiana, under age 21, who are now or will in the future be placed on the Office of Citizens with Developmental Disabilities' (OCDD) Request for Services Registry.

Members of Louisiana's Chisholm class are permitted to participate in Bayou Health physical health services on a voluntary opt-in basis. The members who choose not to opt into Bayou Health physical health services will have their NEMT services covered under Bayou Health NEMT services.

HCBS Waiver Recipients

HCBS recipients were identified using the eligibility groups shown in Appendix C. HCBS recipients are permitted to participate in Bayou Health physical health services on a voluntary opt-in basis. The members who choose not to opt into Bayou Health physical health services will have their NEMT services covered under Bayou Health NEMT services.

Other

The remaining population covered under the NEMT rate is comprised of dually eligible individuals and LTSS recipients. Some dually eligible individuals are included in either the CCM or HCBS Waiver rate cells as a result of the established hierarchy; however, the majority of dually eligible individuals are included in the Other rate cell. These recipients are excluded from Bayou Health physical health services, but will have their NEMT services covered under Bayou Health NEMT services.

Base Data Development

FFS Data and Base Data Adjustments

Mercer utilized claim line level FFS data incurred from January 1, 2013 through December 31, 2013, paid through March 31, 2015, as the base data. Mercer identified the Bayou Health NEMT services populations and identified their NEMT services to be used as the base data. The NEMT services were identified using the claim category of service field "CLC_Claim_Cat_Serv" with the following codes:

- 23 – Non-Emergency Ambulance Transportation
- 92 – Non-Emergency Non-Ambulance Transportation

Mercer reviewed the FFS data to ensure it appeared reasonable and appropriate but did not audit the data. Specifically, Mercer reviewed the completeness and consistency of incurred claims over time.

Mercer reviewed claim lags and determined the NEMT claims were complete with the given runout and thus no adjustment for incurred but not reported claims was necessary for the FFS data.

The base data used for the NEMT rate development can be found in Appendix A. This appendix includes member months, expenses, units, annualized utilization per 1,000 recipients (util/1,000), unit cost, and base data per member per month (PMPM) rate.

Rating Adjustments

Trend

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the expenses of providing NEMT services in a future period. As part of the rate development, Mercer developed the utilization, unit cost, and PMPM trend rates in the table below and applied them to all rate cells equivalently.

Rate Cell	Low Trend	High Trend
CCM	7.0%	9.0%
HCBS	0.0%	1.0%
Other	15.0%	17.0%
Total	**11.8%**	**13.6%**

The base data were trended 30 months, from the midpoint of the CY 2013 base data to the midpoint of the rating period December 1, 2015 through January 31, 2016. Mercer relied upon FFS experience for these populations in developing trend.

Fraud and Abuse Recoupment

Mercer reviewed fraud and abuse recoupments and determined no adjustment was necessary.

Retroactive Eligibility

Mercer reviewed retroactive eligibility and determined no adjustment was necessary.

Managed Care Contracting and Savings Adjustments

Mercer did not apply an adjustment for managed care contracting because Louisiana Medicaid relied upon a sub-contractor to provide the FFS NEMT services during the base data period. Additionally, due to the limited time period covered by these rates, even if the potential for managed care savings does exist, Mercer does not believe significant managed care savings could be realized during the rating period.

Non-Medical Expense Load

Retention

Retention is expressed as a percentage of the gross capitation rate (i.e., premium). These percentages were developed incorporating the following considerations:

- Administrative requirements specific to the NEMT services section of the Bayou Health physical health services contract.
- Administrative expense benchmarks for other Medicaid NEMT services.

- Underwriting gain of 2.00%.
- Premium tax of 2.25%.

Mercer used a total factor of 12.93% for administration expenses, underwriting gain, and premium tax in the development of the NEMT capitation rates.

Rate Ranges

The final rate ranges represent a "best estimate" of the range of anticipated cost of providing NEMT services during the contract period for the covered populations. The lower end of an actuarially sound rate range attempts to ensure the capitation revenue received provides sufficient margin so that insolvency is not a significant risk for the MCOs participating in Bayou Health. The upper end of an actuarially sound rate range attempts to ensure the capitation revenue is not so large that the State is at risk of paying too much for the provision of NEMT services for eligible recipients. Mercer used CY 2013 annual enrollment to calculate the composite capitation rates.

December 1, 2015 through January 31, 2016 Bayou Health NEMT services rate ranges are displayed in the following table:

Category of Aid (COA)	CY 2013 Member Months	Lower Bound	Upper Bound
CCM	62,148	$7.21	$7.55
HCBS	181,177	$12.74	$13.06
Other	1,029,188	$11.34	$11.84
Composite Total	**1,272,513**	**$11.34**	**$11.80**

Please find additional information related to the Bayou Health NEMT services Rate Development in Appendix B.

Certification

In preparing these actuarially sound capitation rate ranges, Mercer has used and relied upon enrollment, eligibility, FFS claims data, and other various information supplied by the State and its fiscal agent. The State and its fiscal agent are responsible for the validity and completeness of these supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion, they are appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies that these rate ranges were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the populations and services covered under the managed care contract. The undersigned actuary is a member of the American Academy of Actuaries and meets its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rate ranges developed by Mercer are actuarial projections of future contingent events. Actual results will differ from these projections. Mercer has developed these rate ranges on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

Providers are advised that the use of these rate ranges may not be appropriate for their particular circumstance, and Mercer disclaims any responsibility for the use of these rate ranges by providers for any purpose. Mercer recommends that any provider considering contracting with the State should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to the rates offered by the State before deciding whether to contract with the State.

This certification letter assumes the reader is familiar with the State's Bayou Health program, Medicaid eligibility rules, and actuarial rating techniques. It is intended for the State and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results. This document should be reviewed only in its entirety.

If you have questions on any of the above, please feel free to contact me at +1 404 442 3358 at your convenience.

Sincerely,



Jaredd Simons, ASA, MAAA
Senior Associate Actuary

Appendix A: NEMT CY 2013 Base Data

COA	CY 2013 Member Months	Total Paid	Units	Annual Util/1,000	Unit Cost	Base PMPM
CCM	62,148	$329,458	4,180	807	$78.82	$5.30
HCBS	181,177	$2,010,030	22,014	1,458	$91.31	$11.09
Other	1,029,188	$7,165,120	104,303	1,216	$68.70	$6.96
Total	**1,272,513**	**$9,504,608**	**130,497**	**1,231**	**$72.83**	**$7.47**

Appendix B: NEMT Rate Development

	Base Data					Rate After Trend			Rate After Retention		
Rate Cell	MMs	Expenses	PMPM	Low Trend	High Trend	Low PMPM	High PMPM	Admin	Low PMPM	High PMPM	Target PMPM
CCM	62,148	$ 329,458	$ 5.30	7.00%	9.00%	$ 6.28	$ 6.58	12.93%	$ 7.21	$ 7.55	$ 7.38
HCBS	181,177	$ 2,010,030	$ 11.09	0.00%	1.00%	$ 11.09	$ 11.37	12.93%	$ 12.74	$ 13.06	$ 12.90
Other	1,029,188	$ 7,165,120	$ 6.96	15.00%	17.00%	$ 9.87	$ 10.31	12.93%	$ 11.34	$ 11.84	$ 11.59
Total	**1,272,513**	**$ 9,504,608**	**$ 7.47**	**11.80%**	**13.62%**	**$ 9.87**	**$ 10.28**	**12.93%**	**$ 11.34**	**$ 11.80**	**$ 11.57**

Appendix C: NEMT Eligibility Designation

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Excluded
SSI (Aged, Blind and Disabled)			
Acute Care Hospitals (LOS > 30 days)			●
BPL (Walker vs. Bayer)			●
Disability Medicaid			●
Disabled Adult Child			●
Disabled Widow/Widower (DW/W)			●
Early Widow/Widowers			●
Family Opportunity Program*			●
Former SSI*			●
Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)			●
PICKLE			●
Provisional Medicaid			●
Section 4913 Children			●
SGA Disabled W/W/DS			●
SSI (Supplemental Security Income)*			●
SSI Conversion			●
Tuberculosis (TB)			●
SSI (OCS Foster Care, IV-E OCS/OYD and OCS/OYD (XIX))			
Foster Care IV-E - Suspended SSI			●
SSI (Supplemental Security Income)			●
TANF (Families and Children, LIFC)			
CHAMP Child			●
CHAMP Pregnant Woman (to 133% of FPIG)			●
CHAMP Pregnant Woman Expansion (to 185% FPIG)			●

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Excluded
Deemed Eligible			●
ELE - Food Stamps (Express Lane Eligibility-Food Stamps)			●
Grant Review			●
LaCHIP Phase 1			●
LaCHIP Phase 2			●
LaCHIP Phase 3			●
LaCHIP Phase IV: Non-Citizen Pregnant Women Expansion			●
LIFC - Unemployed Parent / CHAMP			●
LIFC Basic			●
PAP - Prohibited AFDC Provisions			●
Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL			●
Regular MNP (Medically Needy Program)			●
Transitional Medicaid			●
FCC (Families and Children)			
Former Foster Care children			●
Youth Aging Out of Foster Care (Chaffee Option)			●
FCC (OCS Foster Care, IV-E OCS/OYD and OCS/OYD (XIX))			
CHAMP Child			●
CHAMP Pregnant Woman (to 133% of FPIG)			●
IV-E Foster Care			●
LaCHIP Phase 1			●
OYD - V Category Child			●
Regular Foster Care Child			●
YAP (Young Adult Program)			●

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Excluded
YAP/OYD			●
BCC (Families and Children)			
Breast and/or Cervical Cancer			●
LAP (Families and Children)			
LaCHIP Affordable Plan			●
HCBS Waiver			
ADHC (Adult Day Health Services Waiver)		●	
Children's Waiver - Louisiana Children's Choice		●	
Community Choice Waiver		●	
New Opportunities Waiver – SSI		●	
New Opportunities Waiver Fund		●	
New Opportunities Waiver, non-SSI		●	
Residential Options Waiver - non-SSI		●	
Residential Options Waiver – SSI		●	
SSI Children's Waiver - Louisiana Children's Choice		●	
SSI Community Choice Waiver		●	
SSI New Opportunities Waiver Fund		●	
SSI/ADHC		●	
Supports Waiver		●	
Supports Waiver SSI		●	
CCM			
Chisholm Class Members**		●	
LaHIPP			
Louisiana's Health Insurance Premium Payment Program***			●
Dually Eligible			
Louisiana's Dually Eligible Population****	●	●	

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Excluded
Excluded from Bayou Health Physical Services			
CHAMP Presumptive Eligibility			●
CSOC			●
DD Waiver			●
Denied SSI Prior Period			●
Disabled Adults authorized for special hurricane Katrina assistance			●
EDA Waiver			●
Family Planning, New eligibility / Non-LaMOM			●
Family Planning, Previous LaMOMs eligibility			●
Family Planning/Take Charge Transition			●
Forced Benefits			●
GNOCHC Adult Parent			●
GNOCHC Childless Adult			●
HPE B/CC			●
HPE Children under age 19			●
HPE Family Planning			●
HPE Former Foster Care			●
HPE LaCHIP			●
HPE LaCHIP Unborn			●
HPE Parent/Caretaker Relative			●
HPE Pregnant Woman			●
LBHP - Adult 1915(i)			●
LTC (Long-Term Care)	●		
LTC Co-Insurance			●
LTC MNP/Transfer of Resources	●		
LTC Payment Denial/Late Admission Packet	●		

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Excluded
LTC Spend-Down MNP	●		
LTC Spend-Down MNP (Income > Facility Fee)			●
OCS Child Under Age 18 (State Funded)			●
OYD (Office of Youth Development)			●
PACE SSI			●
PACE SSI-related			●
PCA Waiver			●
Private ICF/DD	●		
Private ICF/DD Spend-Down Medically Needy Program	●		
Private ICF/DD Spend-Down Medically Needy Program/Income Over Facility Fee			●
Public ICF/DD	●		
Public ICF/DD Spend-Down Medically Needy Program	●		
QI-1 (Qualified Individual - 1)			●
QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)			●
QMB (Qualified Medicare Beneficiary)			●
SLMB (Specified Low-Income Medicare Beneficiary)			●
Spend-Down Medically Needy Program			●
Spend-Down Denial of Payment/Late Packet	●		
SSI Conversion / Refugee Cash Assistance (RCA)/ LIFC Basic			●
SSI DD Waiver			●
SSI Payment Denial/Late Admission	●		
SSI PCA Waiver			●
SSI Transfer of Resource(s)/LTC	●		
SSI/EDA Waiver			●

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Excluded
SSI/LTC	●		
SSI/Private ICF/DD	●		
SSI/Public ICF/DD	●		
State Retirees			●
Terminated SSI Prior Period			●
Transfer of Resource(s)/LTC	●		

* Children under 19 years of age who are automatically enrolled into Bayou Health, but may voluntarily disenroll.
** Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the OCDD's Request for Services Registry who are CCMs.
*** LaHIPP is not a category of eligibility. Eligibility designation for LaHIPP enrollees will vary according to the qualifying category of eligibility.
****Dually eligible individuals are identified based on the Medicare Duals Eligibility table supplied by the State's fiscal agent. Dually eligible individuals are represented by Dual Status codes 02, 04, and 08.

MCO Request for Member Disenrollment/Change

To: MAXIMUS

MAXIMUS FAX: 1-888-858-3875

From:

HEALTH PLAN FAX:

Print the Name of Member (Last, First, Middle Initial)	Birth Date	Medicaid ID Number or Social Security Number

☐ Member's utilization of services is fraudulent or abusive (e.g. member loans the MCO issued ID card to another person to obtain services). (Attach narrative with additional information including date of referral to Medicaid Program Integrity's Fraud Hotline)

☐ Member is placed in a long-term care nursing facility, ICF/DD facility, or becomes eligible for a Medicaid Home and Community-Based Services Waiver or hospice. Indicate which _____

☐ Member expired Date: _____

☐Member incarcerated Date:_____ Facility:_____

☐ Member has moved out of state. New Address: _____

☐ Other _____

Health Plan Signature:_____**Date:** _____

The Louisiana Department of Health and Hospitals will determine if the MCO has shown a good cause to disenroll the Medicaid/CHIP member. The Enrollment Broker will give written notification to the MCO of the decision. Medicaid/CHIP members have the right to appeal disenrollment decisions and request a state fair hearing with the Division of Administrative Law. All requests will be reviewed on a case-by-case basis and are subject to the sole discretion of DHH or its designee (Enrollment Broker). All decisions are final and not subject to the dispute resolution process by the MCO. (MCO Request for Proposals, 11.11.4)

The MCO shall not discriminate against any Medicaid /CHIP member on the basis of their health status, need for health care services or any other adverse reason with regard to the member's health, race, sex, handicap, age, religion or national origin.

☐**Disenrollment Approved Effective Date: _____** ☐**Disenrollment Denied/Reason:**_____

DHH Signature:_____**Date:** _____

Maximus Signature:_____**Date**: _____

Health Plan notified of decision.

Appendix UU

Behavioral Health Provider Network - Geographic and Capacity standards

			Monitoring
Psychiatrists	**Rural**	**Urban**	**Quarterly GeoAccess Reports, Network Development Plan, Weekly Provider Registry**
Psychiatrists	**30 miles**	**15 miles**	
Behavioral Health Specialists	**30 miles**	**15 miles**	
Advanced Practice Registered Nurse (Behavioral Health Specialty)	The network standard is applied to this category of providers collectively. However, DHH requires reporting and monitoring for each individual specialist type shown here.		
Clinical Nurse Specialist (Behavioral Health Specialty)			
Licensed Addiction Counselor			
Licensed Clinical Social Worker			
Licensed Marriage and Family Therapist			
Licensed Professional Counselor			
Medical Psychologist			
Physician Assistant(Behavioral Health Specialty)			
Psychologist-Clinical			
Psychologist-Counseling			
Psychologist-Developmental			
Psychologist-General (Non-Declared)			
Pychologist-Other			
Psychologist-School			
Psychiatric Residential Treatment Facilities (PRTFs)	**Travel distance to a PRTF shall not exceed 200 miles for 90% of members**		
Psychiatric Residential Treatment Facility			
Psychiatric Residential Treatment Facility Addiction			
Psychiatric Residential Treatment Facility Hospital Based			
Psychiatric Residential Treatment Facility Other Specialization			
Substance Use Residential Treatment Facilities	**Adolescents**	**Adults**	
ASAM Level III.3/5 Clinically Managed High Intensity	**60 miles**	**30 miles**	
ASAM Level III.7 Medically Monitored Intensive	**n/a**	**60 miles**	
ASAM Level III.7D Medically Monitored Re	**n/a**	**60 miles**	
Other Facilities	**n/a**	**n/a**	
Crisis Receiving Center	The network development plan must include an assessment of coverage for access to these services including distance, population density, and provider availability variables. All gaps in coverage must be identified and addressed in the Network Development Plan		
Repite Care Services Agency/Center Based Respite			
Assertive Community Treatment Team			
Mental Health Clinic (Legacy MHC)			
Behavioral Health Rehab Provider Agency			
Mental Health Rehabilitation Agency			
Multi-Systemic Theraphy Agency			
Therapeutic Group Home			
Mental Health Clinic (Legacy MHC)			
Hospital, Distinct Part Psychiatric Unit			
Hospital, Free Standing Psychiatric Unit			
Federally Qualified Health Clinics (with Behavioral Health Specialty)			
Substance Abuse and Alcohol Abuse Center (Outpatient)			

REQUEST FOR PROPOSALS



BAYOU HEALTH
MANAGED CARE ORGANIZATIONS

LOUISIANA MEDICAID PROGRAM

DEPARTMENT OF HEALTH AND HOSPITALS

BUREAU OF HEALTH SERVICES FINANCING

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

Proposal Due Date/Time:

Release Date:

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1.0 GENERAL INFORMATION

1.1. Background

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

1.1.2. DHH is comprised of the Bureau of Health Services Financing (BHSF) which is the single state Medicaid agency, the Office for Citizens with Developmental Disabilities (OCDD), Office of Behavioral Health (OBH), Office of Aging and Adult Services (OAAS), and the Office of Public Health (OPH). Under the general supervision of the Secretary, these principal offices perform the primary functions and duties assigned to DHH.

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

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

1.2. Purpose of RFP

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

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

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

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

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

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

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

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

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

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

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

1.3. Invitation to Propose

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

1.4. RFP Coordinator

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

Mary Fuentes
Department of Health and Hospitals
Division of Contracts and Procurement Support
P.O. Box 1526
Baton Rouge, LA 70821-1526
(225) 342-5266
Mary.Fuentes@la.gov

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

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

http://www.makingmedicaidbetter.com; and

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

1.5. Communications

All communications relating to this RFP must be directed to the DHH RFP contact person named above. Proposers agree that they shall not rely on any other communications. All communications between Proposers and other DHH staff members concerning this RFP shall be strictly prohibited. Failure to comply with these requirements shall result in proposal disqualification.

1.6. Proposer Comments

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

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

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

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

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

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

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

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

Any and all questions directed to the RFP Coordinator will be deemed to require an official response and a copy of all questions and answers will be posted by the date specified in the Schedule of Events to the following web links:

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

http://www.makingmedicaidbetter.com; and

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

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

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

1.7. Letter of Intent to Propose

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

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

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

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

1.8. Pre-Proposal Conference

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

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

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

http://www.makingmedicaidbetter.com; and

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

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

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

1.9. Schedule of Events

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

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

Systems and Technical Conference	July 31, 2014 1 PM to 4 PM CT Room 118, Bienville Building 628 North 4th St Baton Rouge, LA 70802
Deadline for Receipt of Written Questions	August 4, 2014 11 PM CT
Deadline for Receipt of Letter of Intent to Propose	August 8, 2014 4:00 PM CT
DHH Responses to Written Questions	August 18, 2014 11:00 PM CT
Deadline for Receipt of Follow-Up Written Questions	August 25, 2014 4:00 PM CT
DHH Responses to Follow-Up Written Questions	September 2, 2014
Deadline for Receipt of Written Questions Related to Rate Certification Only	September 8, 2014 4:00 PM CT
DHH Responses to Written Questions Related to Rate Certification Only	September 15, 2014 11:00 PM CT
Deadline for Receipt of Written Proposals	September 26, 2014 4:00 PM CT
Proposal Evaluation Begins	October 1, 2014
Contract Award Announced	October 243, 2014
Contract Begin Date	February 1, 2015

1.10. RFP Addenda

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

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

http://www.makingmedicaidbetter.com; and

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

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

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2.0 SCOPE OF WORK

2.1. Requirements for MCO

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

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

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

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

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

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

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

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

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

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

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

2.2. MCO Project Overview

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

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

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

2.2.4. Management services include but are not limited to:

2.2.4.1. Utilization Management

2.2.4.2. Quality Management and Compliance

2.2.4.3. Prior Authorization

2.2.4.4. Provider Monitoring

2.2.4.5. Member and Provider Services

2.2.4.6. PCP Primary Care Management

2.2.4.7. Fraud and Abuse Monitoring and Compliance

2.2.4.8. Case Management

2.2.4.9. Chronic Care Management

2.2.4.10. Account Management

2.2.4.11. Management of Specialized Behavioral Health Services

2.2.4.12. Integration of Physical and Behavioral Health Services

2.3. General MCO Requirements

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

2.3.2. The MCO shall be responsible for the administration and management of its requirements and responsibilities under the contract with DHH and any and all DHH issued policy manuals and guides. This is also applicable to all subcontractors, employees, agents and anyone acting for or on behalf of the MCO.

2.3.3. The MCO's administrative office shall maintain, at a minimum, business hours of 8:00 a.m. to 5:00 p.m. Central Time Monday through Friday, excluding

recognized Louisiana state holidays and be operational on all DHH regularly scheduled business days. A listing of state holidays may be found at: http://www.doa.louisiana.gov/osp/aboutus/holidays.htm

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

2.3.5. The MCO shall comply with all current state and federal statutes, regulations, and administrative procedures that are or become effective during the term of this Contract. Federal regulations governing contracts with risk-based managed care plans are specified in Section 1903(m) of the Social Security Act and 42 CFR Part 438 and will govern this Contract. DHH is not precluded from implementing any changes in state or federal statutes, rules or administrative procedures that become effective during the term of this Contract and will implement such changes pursuant to Section 23 of this RFP.

2.3.6. The MCO must maintain policy and procedures concerning advance directives with respect to all adult individuals receiving medical services by or through the MCO in accordance with 42 CFR §489.100 and 42 CFR §438.6(i)(1). The written information provided by the MCO must reflect any changes in Louisiana law as soon as possible, but no later than ninety (90) days after the effective date of the change.

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

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

2.3.9. Mental Health Parity

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

~~**2.3.8.1.**~~**2.3.9.2.** The MCO shall develop and maintain internal controls to ensure mental health parity. The health plan's prior authorization policy, procedures, and practices shall comply with The Wellstone – Domenici Mental Health Parity and Addiction Equality Act of 2008 and 45 CFR Parts 146 and 147.

2.3.9.3. The MCO shall require that all providers and all subcontractors take such actions as are necessary to permit the MCO to comply with mental health parity requirements listed in this contract. To the extent that the MCO delegates oversight responsibilities to a third party, the MCO shall require that such third party complies with provisions of this contract relating to mental health parity. The MCO agrees to require, via contract, that such providers comply with regulations and any enforcement actions, including but

not limited to termination and restitution. The MCO shall require mental health parity disclosure on provider enrollment forms as mandated by DHH.

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

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

2.3.10. Physical and Specialized Behavioral Health Integration Requirements

To achieve true integration between physical and behavioral health care for members, the following requirements must be met:

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

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

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

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

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

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

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

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

2.4. Moral and Religious Objections

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

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

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

2.4.1.3. Enrollees within ninety (90) days after adopting the policy with respect to any particular service; and

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

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

2.4.3. Each proposal must include either:

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

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

2.5. Insurance Requirements

2.5.1. General Insurance Information

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

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

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

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

2.5.2. Workers' Compensation Insurance

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

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

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

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

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

2.5.3. Commercial Liability Insurance

2.5.3.1. The MCO shall maintain, during the life of the Contract, Commercial General Liability Insurance to protect the MCO, DHH, and any subcontractor during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as from claims for property damages, which may arise from operations under the contract, whether such operations be by the MCO or by a subcontractor, or by anyone directly or indirectly employed by either of them, or in such a manner as to impose liability to DHH.

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

2.5.3.3. In the absence of specific regulations, the amount of coverage shall be as follows: Commercial General Liability Insurance, including bodily injury, property damage and contractual liability, with a minimum limit per occurrence of $1,000,000 and a minimum general aggregate of $2,000,000.

2.5.4. Reinsurance

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

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

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

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

2.5.5. Errors and Omissions Insurance

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

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

2.5.6. Licensed and Non-Licensed Motor Vehicles

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

2.5.7. Subcontractor's Insurance

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

2.6. Bond Requirements

2.6.1. Performance Bond

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

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

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

2.6.1.4. The bond amount shall be reevaluated and adjusted following~~in~~ the annual open enrollment process, which includes the period during which members can change MCOs without cause.~~third (3rd) month of each contract year.~~ The adjusted amount shall be equal to seventy-five(75%) of the total capitation payment, exclusive of maternity kick payments, paid to the Contractor for ~~in the second (2nd) month of~~ the month following the end of the process.~~contract year.~~ The adjusted bond must be submitted to DHH within 60 days of notification to~~by~~ the MCO~~end~~ of the adjusted amount~~fourth (4th) month of each contract year~~.

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

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

2.6.2. Fidelity Bond

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

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

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3.0 Medicaid Eligibility

3.1 Eligibility Determinations

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

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

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

~~**3.2 Eligibility Criteria**~~

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

3.2 Duration of Medicaid Eligibility

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

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

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

3.3 Eligibility in Bayou Health

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

3.3.2 Populations covered under Bayou Health include:

~~**3.2.1.1**~~**3.3.2.1** Mandatory MCO Populations – All Covered Services (Section 3.4)

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

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

3.3.2.4 Voluntary Opt-In Populations (Section 3.5)

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

3.3.3.1 All covered services

3.3.3.2 Specialized Behavioral Health Services and Non-Emergency Ambulance transportation

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

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

3.4 Mandatory MCO Populations – All Covered Services

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

~~3.2.2~~3.4.1 Children under nineteen (19) years of age including those who are eligible under Section 1931 poverty-level related groups and optional groups of older children in the following categories:

~~3.2.2.1~~3.4.1.1 TANF - Individuals and families receiving cash assistance through FITAP, administered by the DCFS;

~~3.2.2.2~~3.4.1.2 CHAMP-Child Program – Poverty level children up to age nineteen (19) who meet financial and non-financial eligibility criteria. Deprivation or uninsured status is not an eligibility requirement;

~~3.2.2.3~~3.4.1.3 Deemed Eligible Child Program - Infants born to Medicaid-eligible pregnant women, regardless of whether or not the infant remains with the birth mother, throughout the infant's first year of life;

~~3.2.2.4~~3.4.1.4 Youth Aging Out of Foster Care (Chafee Option)- Children under age twenty-one (21) who were in foster care (and already covered by Medicaid) on their eighteenth (18th) birthday, but have aged out of foster care;

~~3.2.2.5~~3.4.1.5 Former Foster Care Children – covers individuals age eighteen (18) through twenty-six (26) who were receiving Medicaid benefits and in foster care at the time that they obtained age eighteen (18.)

~~3.2.2.6~~3.4.1.6 Regular Medically Needy Program - Individuals and families who have more income than is allowed for regular on-going Medicaid; and

~~3.2.2.7~~3.4.1.7 LaCHIP Program - Children enrolled in the Title XXI Medicaid expansion and separate CHIP programs for low-income children under age nineteen (19) who do not otherwise qualify for Medicaid.

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

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

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

~~3.2.3~~3.4.2 Parents and Caretaker Relatives eligible under Section 1931 of the Social Security Act including:

~~3.2.3.1~~3.4.2.1 Parents and Caretaker Relatives Program

~~3.2.3.2~~3.4.2.2 TANF (FITAP) Program

~~3.2.3.3~~3.4.2.3 Regular Medically Needy Program

~~3.2.4~~3.4.3 Pregnant Women - Individuals whose basis of eligibility is pregnancy, who are eligible only for pregnancy related services [42 CFR §440.210(2)] including:

~~3.2.4.1~~3.4.3.1 LaMOMS (CHAMP-Pregnant Women) - Pregnant women otherwise ineligible who receive coverage for prenatal care, delivery, and care through the second calendar month following the end of pregnancy.

~~3.2.4.2~~3.4.3.2 LaCHIP Phase IV Program – Separate state CHIP Program for CHIP Unborn Option which covers uninsured pregnant women ineligible for Medicaid until end of pregnancy and completion of administrative determination of continued eligibility in any other Medicaid program.

~~3.2.5~~3.4.4 Breast and Cervical Cancer (BCC) Program - Uninsured women under age sixty-five (65) who are not otherwise eligible for Medicaid and are identified through the Centers for Disease Control (CDC) National Breast and Cervical Cancer Early Detection Program as being in need of treatment for breast and/or cervical cancer, including pre-cancerous conditions and early stage cancer.

~~3.2.6~~3.4.5 Aged, Blind and Disabled Adults – Individuals ~~–~~who do not meet any of the conditions for~~–~~, mandatory enrollment~~exclusion from participation~~ in the~~an~~ MCO for specialized behavioral health as covered in Sections 3.5, 3.6, and 3.7. These include~~, including~~:

~~3.2.6.1~~3.4.5.1 Supplemental Security Income (SSI) Program – Individuals nineteen (19) and older who receive cash payments under Title XVI (Supplemental Security Income) administered by the Social Security Administration; and

~~3.2.6.2~~3.4.5.2 Extended Medicaid Programs - Certain individuals who lose SSI eligibility because of a Social Security cost of living adjustment (COLA) or in some cases entitlement to or an increase in Retirement, Survivors, Disability Insurance (RSDI) benefits, i.e., Social Security benefits. SSI income standards are used in combination with budgeting rules which allow the exclusion of cost of living adjustments and/or certain benefits. Extended Medicaid consists of the following programs:

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

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

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

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

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

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

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

~~3.2.6.3~~3.4.5.3 Medicaid Purchase Plan Program - Working individuals between ages 16 and 65 who have a disability that meets Social Security standards; ~~and~~

~~3.2.6.4~~3.4.5.4 Provisional Medicaid Program – People with disabilities and aged (65 or older) individuals who meet eligibility requirements of the SSI program as determined by DHH, without having an SSI determination made by SSA; and~~.~~

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

~~3.2.7~~3.4.6 Continued Medicaid Program - Short-term coverage for families who lose Parents and Caretaker Relatives or TANF eligibility because of an increase in earnings or an increase in the hours of employment.

~~3.2.8~~3.4.7 Individuals who have been diagnosed with tuberculosis, or are suspected of having tuberculosis, and are receiving TB related services through the TB Infected Individual Program.

~~3.3~~3.5 Voluntary Opt-In~~Out~~ Populations

~~Medicaid populations that are automatically enrolled into Bayou Health but may voluntarily disenroll from Bayou Health include:~~

~~3.3.1.1~~ Medicaid populations that are mandatorily enrolled into Bayou Health ~~Children under nineteen (19) years of age who are:~~

- ~~Eligible~~ for Specialized Behavioral Health and NEMT services~~SSI under title XVI of the Social Security Act;~~
- ~~Eligible under Section 1902(e)(3) of the Social Security Act;~~
- ~~In foster care or other out-of-home placement;~~
- ~~Receiving foster care or adoption assistance;~~
- ~~Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of title V of the Social Security Act,~~ and NEMT Services only,~~is defined by the DHH in terms of either program participation or special health care needs; or~~
- ~~Enrolled in the Family Opportunity Act Medicaid Buy-In Program.~~

~~3.3.2 Native Americans who are members of federally recognized tribes, except when the MCO is:~~

- ~~The Indian Health Service; or~~

- ~~An Indian health program or urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service.~~

~~3.3.3~~ ~~Voluntary opt-out populations may voluntarily disenroll within ninety (90) days of initial enrollment~~ and ~~during annual open enrollment.~~

~~3.3.4~~ ~~DHH may pursue a change in federal authority for the Bayou Health Program to 1915(b) of the Social Security Act to mandate enrollment of Voluntary Opt-Out populations.~~

~~3.4 Voluntary Opt-In Populations~~

~~3.4.1~~3.5.1 ~~Medicaid populations that are not automatically enrolled into Bayou Health but~~ may voluntarily enroll into Bayou Health for other state plan covered services, include:

~~3.4.1.1~~3.5.1.1 Non-dually eligible individuals~~Individuals~~ receiving services through the following~~any~~ 1915(c) Home and Community-Based Waivers~~Waiver including, but not limited to~~:

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

~~3.4.1.2~~3.5.1.2 Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the Office for Citizens with Developmental Disabilities' (OCDD's) Request for Services Registry who are *Chisholm* Class Members.

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

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

3.4.43.5.4 Voluntary opt- in populations who have previously returned to Legacy Medicaid for all state plan services other than Specialized Behavioral Health and NEMT may exercise this option to return todisenrolled from Bayou Health for other state plan servicesmay reenroll in Bayou Health only during the annual open enrollment period effective the earliest month that the action can be administratively taken.

Mandatory MCO

3.53.6 Excluded Populations – Specialized Behavioral Health and Non-Emergency Ambulance Transportation

The followingMedicaid populations are mandatorily enrolledthat cannot participate in Bayou Health for Specialized Behavioral Health Services and Non-Emergency Ambulance Transportation only: include:

3.6.1 Individuals residing in Nursing Facilities (NF); and

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

3.7 Mandatory MCO Populations – Specialized Behavioral Health and NEMT Services

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

3.8 Excluded Populations

3.8.1 Medicaid populations that cannot participate in Bayou Health include:

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

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

3.8.1.3 Refugee Cash Assistance;

3.8.1.4 Refugee Medical Assistance;

3.8.1.5 Take Charge Plus;

3.8.1.6 SLMB only;

3.8.1.7 QI 1;

3.8.1.8 LTC Co-Insurance;

3.8.1.9 QDWI;

3.8.1.10 QMB only; and

~~3.5.2.2~~**3.8.1.11** Individuals with a limited eligibility period including:

~~3.5.2.2.1~~**3.8.1.11.1** Spend-down Medically Needy Program - An individual or family who has income in excess of the prescribed income standard can reduce excess income by incurring medical and/or remedial care expenses to establish a temporary period of Medicaid coverage (up to three (3) months);

~~3.5.2.2.2~~**3.8.1.11.2** Emergency Services Only - Emergency services for aliens who do not meet Medicaid citizenship/ 5-year residency requirements; and

3.8.1.11.3 Greater New Orleans Community Health Connection (GNOCHC) Program

~~**3.5.2.2.3** Individuals enrolled in the Family Planning Program that provides family planning services only.~~

~~3.5.3~~**3.8.2** DHH may add, delete, or otherwise change mandatory, voluntary opt-out, voluntary opt-in, and excluded population groups. If changed, the Contract shall be amended and the MCO given sixty (60) days advance notice whenever possible.

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4.0 STAFF REQUIREMENTS AND SUPPORT SERVICES

4.1. General Staffing Requirements

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

4.1.2 For the purposes of this contract, the MCO shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR §438.610(a) and (b), 42 CFR §1001.1901(b), 42 CFR §1003.102(a)(2)]. The MCO must screen all employees and sub-contractors to determine whether any of them have been excluded from participation in federal health care programs. The Health and Human Services-Office of Inspector General (HHS-OIG) website, which can be searched by the names of any individual, can be accessed at the following url: https://oig.hhs.gov/exclusions/index.asp

4.1.3 The MCO must employ sufficient staffing and utilize appropriate resources to achieve contractual compliance. The MCO's resource allocation must be adequate to achieve outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with contractual and DHH policy requirements, including the requirement for providing culturally competent services. If the MCO does not achieve the desired outcomes or maintain compliance with contractual obligations, additional monitoring and regulatory action may be employed by DHH, including but not limited to requiring the MCO to hire additional staff and application of monetary penalties as specified in Section 20 of this RFP.

4.1.4 The MCO shall comply with DHH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of DHH contractors who have access to electronic protected health information on Medicaid applicants and recipients. It shall, upon request, provide DHH with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this Contract.

4.1.5 The MCO shall be responsible for any additional costs associated with on-site audits or other oversight activities that result when required systems are located outside of the state of Louisiana.

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

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

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

4.2 Key Staff Positions

4.2.1 Staffing Requirements

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

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

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

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

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

4.2.1.6 Annually, the MCO must provide the name, Social Security Number and date of birth of the staff members performing the duties of the key staff. DHH will compare this information against federal databases to confirm that those individuals have not been banned or debarred from participating in federal programs [42 CFR §455.104].

4.2.1.7 Exception to Staffing Requirements

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

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

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

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

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

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

- Development, implementation and medical interpretation of medical policies and procedures including, but not limited to, service authorization, claims review, discharge planning, credentialing and referral management, and medical review included in the MCO Grievance System;
- Administration of all medical management activities of the MCO;
- Serve as member of and participate in every quarterly and phone meeting of the Medicaid Quality Committee either in person or by phone. Medical Director may designate a representative with a working understanding of the clinical and quality issues impacting Medicaid; and
- Serve as the director of the Utilization Management committee and chairman or co-chairman of the Quality Assessment and Performance Improvement committee.

4.2.4 **Behavioral Health Medical Director** who is a physician with a current, unencumbered Louisiana-license asthrough a physician, board-certified in psychiatry with at least three (3) years of training in a medical specialty. The Behavioral Health State Board of Medical Director shall devote fullExaminers and who is at least one quarter time (minimum 3210 hours weekly) senior executive dedicated to this Agreement who is a board-certified psychiatrist in the MCO's operations to ensure timely medical decisions, including after-hours consultation as needed. During periods when the Behavioral Health Medical Director is not available, the MCO shall have physician staff to provide competent medical direction. The Behavioral Health Medical Director will share responsibility to manage the behavioralState of Louisiana and has at least five (5) years of combined experience in mental health and substance abuse services delivery system with the Behavioral Health Coordinator, and shall. Must be

~~located in Louisiana or available to Louisiana for consultation. This person shall oversee and~~ be actively involved in ~~responsible for~~ all major ~~Behavioral Health activities within the MCO and take an active role in the contractor's medical management team and in~~ clinical and quality management components of the behavioral health services of the MCO. The Behavioral Health Medical Director shall meet regularly with the Chief Medical Officer~~policy decisions~~. The Behavioral Health Medical Director's responsibilities shall include, but not be limited to the following:

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

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

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

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

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

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

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

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

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

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

4.2.7 **Program Integrity Officer** who is qualified by training and experience in health care or risk management, to oversee monitoring and enforcement of the fraud, waste, and abuse compliance program to prevent and detect potential fraud, waste, and abuse activities pursuant to state and federal rules and regulations,

and carry out the provisions of the compliance plan, including fraud, waste, and abuse policies and procedures, investigating unusual incidents and implementing any corrective action plans. As a management official, this position shall have the authority to assess records and independently refer suspected member fraud, provider fraud, and member abuse cases to DHH and other duly authorized enforcement agencies. Position must report directly to the CEO.

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

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

4.2.10 **Contract Compliance Coordinator** who will serve as the primary point-of-contact for all MCO contract compliance issues. These primary functions may include but are not limited to coordinating the tracking and submission of all contract deliverables; fielding and coordinating responses to DHH inquiries, coordinating the preparation and execution of contract requirements, random and periodic audits and *ad hoc* visits.

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

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

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

- Focusing organizational efforts on improving clinical quality performance measures;

- Developing and implementing performance improvement projects;

- Utilizing data to develop intervention strategies to improve outcome; and

- Reporting quality improvement/performance outcomes.

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

- Ensuring receipt of EPSDT services;

- Ensuring receipt of maternal and postpartum care;

- Promoting family planning services;

- Promoting preventive health strategies;

- Identifying and coordinating assistance for identified member needs specific to maternal/child health and EPSDT;

- Interfacing with community partners.

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

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

- Ensuring that appropriate concurrent review and discharge planning of inpatient stays is conducted;

- Developing, implementing and monitoring the provision of care coordination, disease management and case management functions;

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

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

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

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

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

- Developing and implementing claims processing systems capable of paying claims in accordance with state and federal requirements and the terms of the Contract;

- Developing processes for cost avoidance;

- Ensuring minimization of claims recoupments;

- Meeting claims processing timelines; and

- Meeting DHH encounter reporting requirements.

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

- Educating in-network and out-of-network providers (i.e., professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available MCO resources such as provider manuals, websites, fee schedules, etc.;

- Interfacing with the MCO's call center to compile, analyze, and disseminate information from provider calls;

- Identifying trends and guiding the development and implementation of strategies to improve provider satisfaction; and

- Frequently communicating (i.e., telephonic and on-site) with providers to ensure the effective exchange of information and to gain feedback regarding the extent to which providers are informed about appropriate claims submission practices.

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

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

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

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

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

4.2.24 **Addictionologist or an Addiction Services Manager (ASM)** who must meet the requirements of a licensed addiction counselor (LAC) or LMHP with at least seven (7) years of clinical experience with addiction treatment of adults and children experiencing substance use problems and disorders. The ASM shall be responsible for oversight and compliance with the addiction principles of care and application of American Society of Addiction Medicine (ASAM) placement

criteria for all addiction program development. The ASM will work closely with the COO, the Behavioral Health Coordinator, the Quality Management Coordinator, and the Behavioral Health Medical Director in assuring quality, appropriate utilization management, and adequacy of the addiction provider network.

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

4.3 Additional Required Staff

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

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

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

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

4.3.2.1 The MCO shall have a sufficient number of LMHPs, including licensed addiction counselors (LACs), as well as a board-certified psychiatrist and a board-certified addictionologist. If an addictionologist cannot be retained full-time due to limited availability, the MCO shall contract with a qualified consultant. With the exception of the addictionologist who shall be available

at least 10 hours per week, the other LMHPs shall be available 24 hours per day/7 days per week. The MCO shall provide UM staff, both experienced and specifically assigned to children, youth, adults, and older adults, and PSH.

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

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

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

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

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

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

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

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

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

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

criteria as established by the State. LMHPs shall be certified in administering the Level of Care Utilization System (LOCUS).

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

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

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

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

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

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

4.3.12.5 Behavioral health consumer and family organizations liaison for children, youth and adults. This person shall be a peer, former consumer of services and/or in recovery. This liaison shall be engaged with the advocacy community.

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

4.4 In-State ~~Key~~ Staff Positions

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

4.4.1 Administrator/Chief Executive Officer

4.4.2 Chief Operating Officer/COO

4.4.3 Medical Director/CMO

4.4.4 Behavioral Health Medical Director

4.4.5 Program Integrity Officer

4.4.6 Grievance System Manager

4.4.7 Contract Compliance Coordinator

4.4.8 Quality Management Coordinator

4.4.9 Maternal Health/EPSDT (Child Health) Coordinator

4.4.10 Medical Management Manager

4.4.11 Member Services Manager

4.4.12 Provider Services Manager

4.4.13 Provider Claims Educator (if applicable)

4.4.14 Encounter Data Quality Coordinator

4.4.15 Case Management Staff

4.4.16 Fraud, Waste, and Abuse Investigators (at a rate of one per one hundred thousand and fraction thereof (1:100,000) members

4.4.17 Behavioral Health Liaisons

4.4.18 Behavioral Health Coordinator

4.4.19 Behavioral Health Children's System Administrator

4.4.20 Addictionologist or Addiction Services Manager

4.4.21 Behavioral Health Case Management Supervisor

4.5 Written Policies, Procedures, and Job Descriptions

4.5.1 The MCO shall develop and maintain written policies, procedures and job descriptions for each functional area, including for specialized behavioral health services, consistent in format and style. The MCO shall maintain written guidelines for developing, reviewing and approving all policies, procedures and job descriptions. All policies and procedures shall be reviewed at least annually to ensure that the MCO's written policies reflect current practices. Reviewed policies shall be dated and signed by the MCO's appropriate manager, coordinator, director or administrator. Minutes reflecting the review and approval of the policies by an appropriate committee are also acceptable documentation. All medical and quality management policies must be approved and signed by the MCO's Medical Director. All behavioral health policies must be approved and signed by the MCO's Behavioral Health Medical Director. Job descriptions shall be reviewed at least annually to ensure that current duties performed by the employee reflect written requirements.

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

4.6 Staff Training and Meeting Attendance

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

4.6.2 The MCO must provide initial and ongoing staff training that includes an overview of DHH, DHH Policy and Procedure Manuals, and Contract and state and federal requirements specific to individual job functions. The MCO shall ensure that all staff members having contact with members or providers receive initial and ongoing training with regard to the appropriate identification and handling of quality of care/service concerns.

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

4.6.4 The MCO shall provide the appropriate staff representation for attendance and participation in meetings and/or events scheduled by DHH. All meetings shall be considered mandatory unless otherwise indicated.

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

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

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

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

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

4.6.7.1.2 OJJ system, population, and processes;

4.6.7.1.3 DCFS system, population, and processes;

4.6.7.1.4 Contract requirements;

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

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

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

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

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

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

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

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

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5.0 MCO REIMBURSEMENT

5.1. Capitated Payments

5.1.1. DHH shall make monthly ~~risk-adjusted~~ capitated payments for each member enrolled into the MCO.

~~The MCO shall agree to accept, as payment in full, the actuarially sound rate and maternity kick payment established by DHH pursuant to the contract, and shall not seek additional payment from a member, or DHH, for any unpaid cost.~~The monthly capitated payment shall be based on member enrollment for the month.

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

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

5.2. Maternity Kick Payments

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

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

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

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

5.3. MCO Payment Schedule

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

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

5.4. Withhold of Capitated Payment~~Capitation Rate~~

5.4.1. A withhold of the monthly capitated~~aggregate capitation rate~~ payment shall be applied to provide an incentive for MCO compliance with the requirements of this Contract.

5.4.2. The ~~capitation rate payment~~ withhold amount will be equivalent to two percent (2%) of the monthly capitated~~capitation rate~~ payment for physical and basic behavioral health for all MCO enrollees, exclusive of maternity kick payments and the Full Medicaid Payment (FMP) component of the monthly capitated~~capitation rate~~ payment.

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

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

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

~~**5.4.6.**~~ If the same or similar deficiency(s) continues beyond timeframes specified for correction in the written notice of action, which shall be considered the cure period ~~(6) consecutive months~~, DHH may permanently retain the amount withheld for the period of non-compliance consistent with the monetary penalty, sanctions, and liquidated damages provisions of this Contract.~~,~~

~~**5.4.7.**~~

~~Amounts withheld for MCO Incentive Based Performance Measure outcomes, as defined in Section 14.2.5., are exempt from the six (6) consecutive months duration provision of Section 5.1.6.5.3.6 and may be permanently retained upon validation of calculated rate by DHH's contracted external quality review organization.~~

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

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

~~**Payment Adjustments**~~

~~**5.4.8.**~~**5.4.6.**

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

~~**5.4.9.**~~**5.4.7.** Amounts withheld for MCO Incentive Based Performance Measure outcomes, as defined in Section 14.2.5., may be permanently retained upon validation of calculated rate by DHH's contracted external quality review organization.

~~**5.4.10.**~~**5.4.8.** No interest shall be due to the MCO on any sums withheld or retained under this Section.

~~5.4.11.~~5.4.9. The provisions of this Section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under this Contract.

5.5. Payment Adjustments

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

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

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

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

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

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

5.6. Risk Sharing

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

~~5.6.1.~~5.6.2. The MCO shall assume one hundred percent (100%) liability for any expenditure above the monthly capitated~~capitation~~ rate and maternity kick payment.

5.7. Determination of MCO Rates

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

5.7.2. Rates will be set using fee-for-service claims data, Bayou Health Shared Savings claims experience, Bayou Health MCO encounter data, LBHP encounter data, and financial data and supplemental *ad hoc* data and analyses appropriate for determining actuarially sound rates. Fiscal periods of the base data will be determined based upon the data sources, rate periods and purposes for which the data is used with appropriate adjustments which include the following:

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

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

5.7.2.3. Third Party Liability recoveries; and

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

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

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

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

5.7.3.3. Legislative appropriations and budgetary constraints; or

5.7.3.4. Changes in federal requirements.

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

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

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

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

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

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

5.8. Risk Adjustment

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

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

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

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

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

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

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

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

5.9. Medical Loss Ratio

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

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

5.9.1.1.1. If the aggregate MLR (cost for health care benefits and services and specified quality expenditures) is less than eighty-five percent (85%), the MCO shall refund DHH the difference. Any unpaid balances after

the refund is due shall be subject to interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher. ~~(See also Appendix H – **Medical Loss Ratio (MLR) Requirements** for MLR calculation methodology and classification of costs.)~~

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

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

~~**5.1. Co-payments**~~

~~Any cost sharing imposed on Medicaid members must be in accordance with 42 CFR §447.50 - §447.57 and cannot exceed cost sharing amounts in the Louisiana Medicaid State Plan. DHH reserves the right to amend cost sharing requirements.~~

5.10. Return of Funds

5.10.1. All amounts owed by the MCO to DHH, as identified through routine or investigative reviews of records or audits conducted by DHH or other state or federal agency, are due no later than thirty (30) calendar days following notification to the MCO by DHH unless otherwise authorized in writing by DHH. DHH, at its discretion, reserves the right to collect amounts due by withholding and applying all balances due to DHH to future payments. DHH reserves the right to collect interest on unpaid balances beginning thirty (30) calendar days from the date of initial notification. Any unpaid balances after the refund is due shall be subject to interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher.

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

5.11. Other Payment Terms

~~**5.10.3.**~~**5.11.1.** The MCO shall make payments to its providers as stipulated in the contract.

~~**5.10.4.**~~**5.11.2.** The MCO shall not assign its right to receive payment to any other entity.

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

5.11.4. The MCO shall agree to accept payments as specified in this Section and have written policies and procedures for receiving and processing payments and adjustments. Any charges or expenses imposed by financial institutions for transfers or related actions shall be borne by the MCO.

5.12. Cost Sharing

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

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

5.12.3. DHH reserves the right to amend cost sharing requirements

5.12.4. An MCO or its subcontractors may not:

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

~~5.10.4.1.~~**5.12.4.2.** Restrict its members' access to needed drugs and related pharmaceutical products by requiring that members use mail-order pharmacy providers; or

~~5.10.4.2.~~**5.12.4.3.** Impose copayments for the following:

- Family planning services and supplies;
- Emergency services;
- Services provided to:
  - Individuals younger than 21 years old;
  - Pregnant women;
  - Individuals who are inpatients in long-term care facilities or other institutions;
  - Native Americans; and
  - Alaskan Eskimos

~~5.11.~~5.13. Third Party Liability (TPL)

~~5.11.1.~~5.13.1. General TPL Information

~~5.11.1.1.~~**5.13.1.1.** Pursuant to federal and state law, the Medicaid program by law is intended to be the payer of last resort. This means all other available Third Party Liability (TPL) resources must meet their legal obligation to pay claims before the MCO pays for the care of an individual eligible for Medicaid.

~~5.11.1.2.~~**5.13.1.2.** The MCO shall take reasonable measures to determine TPL.

~~5.11.1.3.~~**5.13.1.3.** The MCO shall coordinate benefits in accordance with 42 CFR §433.135, et seq. and La. R.S. 46:460.71, so that costs for services otherwise payable by the MCO are cost avoided or recovered from a liable party. The two methods used are cost avoidance and post-payment

recovery. The MCO shall use these methods as described in federal and state law.

~~5.11.1.4.~~5.13.1.4. Establishing TPL takes place when the MCO receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or services delivered to a member.

~~5.11.1.5.~~5.13.1.5. If the probable existence of TPL cannot be established the MCO must adjudicate the claim. The MCO must then utilize post-payment recovery if TPL is later determined to exist which is described in further detail below.

~~5.11.1.6.~~5.13.1.6. The term "state" shall be interpreted to mean "MCO" for purposes of complying with the federal regulations referenced above. The MCO may utilize subcontractors to comply with coordination of benefit efforts for services provided pursuant to this contract.

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

~~5.11.1.7.~~5.13.1.8. MCO must verify and add Medicaid recipient insurance updates for their members to their system within five business days of receipt. If a member is unable to access services or treatment until an update is made, update requests for that member must be verified and added within four business hours. These updates must be submitted to the DHH fiscal intermediary on the daily file load on the day the update is made. This includes updates on coverage, including removal of coverage that existed prior to the members linkage to the MCO that impacts current provider adjudication or member service access (i.e. pharmacy awaiting TPL update to fulfill prescription).

~~5.11.2.~~5.13.2. Cost Avoidance

~~5.11.2.1.~~5.13.2.1. The MCO shall cost-avoid a claim if it establishes the probable existence of TPL at the time the claim is filed.

~~5.11.2.2.~~5.13.2.2. The MCO may "pay and chase" the full amount allowed under the MCO payment schedule for the claim and then seek reimbursement for any liable TPL of legal liability if:

~~5.11.2.3.~~5.13.2.3. The claim is for labor and delivery and postpartum care (cost associated with the inpatient hospital stay for labor and delivery and post-partum care must be cost-avoided);

~~5.11.2.4.~~5.13.2.4. The claim is for prenatal care for pregnant women, or preventive pediatric services (including EPSDT);

~~5.11.2.5.~~5.13.2.5. The claim is for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D agency. The MCO must seek recovery of reimbursement within sixty (60) days after the end of the month in which the payment was made.

~~5.11.2.6.~~5.13.2.6. If a TPL insurer requires the member to pay any co-payment, coinsurance or deductible, the MCO is responsible for making these payments under the method described below, even if the services are provided outside of the MCO network.

Scenario 1 Professional Claim

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

(Medicaid pays the allowable amount minus TPL payment OR total patient responsibility amount (co-pay, co-insurance, and/or deductible). The Medicaid allowed amount minus the TPL paid amount is LESS than the patient responsibility; thus, the Medicaid allowed amount is the payment.)

Scenario 2 Outpatient Claim

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

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

Scenario 3 Inpatient Claim

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

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

~~5.11.3.~~5.13.3. Post-payment Recoveries

~~5.11.3.1.~~5.13.3.1. Post-payment recovery is necessary in cases where the MCO has not established the probable existence of TPL at the time services were rendered or paid for, or was unable to cost avoid. The following sets forth requirements for MCO recovery:

~~5.11.3.2.~~5.13.3.2. The MCO must seek recovery of reimbursement within sixty (60) days after the end of the month it learns of the existence of the liable third party after a claim is paid.

~~5.11.3.3.~~5.13.3.3. The MCO must have established procedures for recouping post-payments for DHH's review during the Readiness Review process. The MCO must void encounters for claims that are recouped in full. For recoupments that are not recouped in full, the MCO must submit adjusted encounters for the claims.

~~5.11.3.4.~~5.13.3.4. The MCO shall identify the existence of potential TPL to pay for core benefits and services through the use of trauma code edits in accordance with 42 CFR §433.138(e).

~~5.11.3.5.~~5.13.3.5. The MCO shall be required to seek reimbursement in accident/trauma related cases when claims in the aggregate equal or exceed $500 as required by the Louisiana Medicaid State Plan and federal Medicaid guidelines and may seek reimbursement when claims in the aggregate are less than five hundred dollars ($500).

~~5.11.3.6.~~5.13.3.6. The amount of any recoveries collected by the MCO outside of the claims processing system shall be treated by the MCO as offsets to medical expenses for the purposes of reporting.

~~5.11.3.7.~~5.13.3.7. Prior to accepting a TPL settlement on accident/trauma-related claims equal to or greater than twenty-five thousand dollars ($25,000), the MCO shall obtain approval from DHH.

~~5.11.4.~~5.13.4. Distribution of TPL Recoveries

~~5.11.4.1.~~5.13.4.1. The MCO may retain up to 100% of its TPL collections if all of the following conditions exist:

~~5.11.4.2.~~5.13.4.2. Total collections received do not exceed the total amount of the MCO financial liability for the member;

~~5.11.4.3.~~5.13.4.3. There are no payments made by DHH related to fee-for-service, reinsurance or administrative costs (*i.e.,* lien filing, etc.);

~~5.11.4.4.~~5.13.4.4. Such recovery is not prohibited by state or federal law; and

~~5.11.4.5.~~5.13.4.5. DHH will utilize the data in calculating future capitation rates.

~~5.11.5.~~5.13.5. TPL Reporting Requirements

~~5.11.5.1.~~5.13.5.1. The MCO shall provide DHH TPL information in a format and medium described by DHH and shall cooperate in any manner necessary, as requested by DHH, with DHH and/or a cost recovery vendor of DHH.

~~5.11.5.2.~~5.13.5.2. The MCO shall be required to include the collections and claims information in the encounter data submitted to DHH, including any retrospective findings via encounter adjustments.

~~5.11.5.3.~~5.13.5.3. Upon the request of DHH, the MCO must provide information not included in encounter data submissions that may be necessary for the administration of TPL activity. The information must be provided within thirty (30) calendar days of DHH's request. Such information may include, but is not limited to, individual medical records for the express purpose of a TPL resource to determine liability for the services rendered.

~~5.11.5.4.~~5.13.5.4. Upon the request of DHH, the MCO shall demonstrate that reasonable effort has been made to seek, collect and/or report TPL and recoveries. DHH shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices.

~~5.11.5.5.~~5.13.5.5. The MCO is required to submit an annual report of all health insurance collections for its members plus copies of any Form 1099's received from insurance companies for that period of time.

~~5.11.6.~~5.13.6. DHH Right to Conduct Identification and Pursuit of TPL

~~5.11.6.1.~~5.13.6.1. DHH may invoke its right to pursue recovery if the MCO fails to recover reimbursement from the third party to the limit of legal liability within three hundred sixty-five (365) days from date of service of the claims(s).

~~5.11.6.2.~~5.13.6.2. If DHH determines that the MCO is not actively engaged in cost avoidance activities the MCO shall be subject to monetary penalties in an amount not less than three times the amount that could have been cost avoided.

~~5.12.~~5.14. Coordination of Benefits

~~5.12.1.~~5.14.1. Other Coverage Information

The MCO shall provide TPL information for each member in accordance with Sections 5.12. A weekly file will be sent to DHH reporting additions and updates of TPL information in a format and medium specified by DHH. The MCO shall reconcile the TPL file with the Louisiana Medicaid Fiscal Intermediary and claims shall be adjudicated based off the State's resource file.

~~5.12.2.~~5.14.2. Reporting and Tracking

The MCO's system shall identify and track potential collections. The system should produce reports indicating open receivables, closed receivables, amounts collected, amounts written off and amounts avoided.

~~**Copays/Cost Share**~~

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

~~An MCO or its subcontractors may not:~~

~~**5.1.1.1.** Deny services to an individual who is eligible for services because of the individual's inability to pay the cost sharing;~~

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

~~Impose copayments for the following:~~

~~Family planning services and supplies~~

~~Emergency services;~~

~~Services provided to:~~

~~Individuals younger than 21 years old;~~

~~Pregnant women;~~

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

~~Native Americans; and~~

~~Alaskan Eskimos.~~

~~5.13.~~5.15. Financial Disclosures for Pharmacy Services

The MCO must disclose all financial terms and arrangements for remuneration of any kind that apply between the MCO or the MCO's PBM subcontractor and any prescription drug wholesaler, manufacturer or labeler, including, without limitation, formulary management, educational support, claims processing, pharmacy network fees, drug product sales or pricing agreements, data sales fees, and any other fees. Section 16 of this contract provides that DHH or state auditors may audit such information at any time. DHH agrees to maintain the confidentiality of information disclosed by the MCO pursuant to the contract, to the extent that such information is confidential under Louisiana or federal law.

~~5.14.~~5.16. Health Insurance Provider Fee (HIPF) Reimbursement

If the MCO is identified by the Internal Revenue Service (IRS) as a covered entity and thereby subject to an assessed fee ("Annual Fee") whose final calculation includes an

applicable portion of the MCO's net premiums written from DHH's Medicaid/CHIP lines of business, DHH shall, upon the MCO satisfying completion of the requirements below, make an annual payment to the MCO in each calendar year payment is due to the IRS (the "Fee Year"). This annual payment will be calculated by DHH (and its contracted actuary) as an adjustment to each MCO's capitation rates for the full amount of the Annual Fee allocable to Louisiana Medicaid/CHIP with respect to premiums paid to the MCO for the preceding calendar year (the "Data Year.") The adjustment will be to the capitation rates in effect during the Data Year.

~~5.14.1.~~5.16.1. The MCO shall, at a minimum, be responsible for adhering to the following criteria and reporting requirements:

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

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

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

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

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

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

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

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

5.16.2. For covered entities subject to the HIPF, DHH will perform the following steps to evaluate and calculate the HIPF percentage based on the Contractor's notification of final fee calculation (i.e., HIPF liability) and all premiums for the

Contractor subject to Section 9010, as reported on the Contractor's Form 8963, and agreed reasonable by DHH.

5.16.2.1. Review each submitted document and notify the Contractor of any questions.

5.16.2.2. DHH will check the reasonableness of the MCO's Louisiana-specific Medicaid/CHIP premium revenue included on the MCO's Form 8963/supplemental delineation. This reasonableness check will include, but may not be limited to comparing the MCO's reported Louisiana-specific Medicaid/CHIP premium revenue to DHH's capitation payment records.

5.16.2.3. DHH and its actuary will calculate revised Data Year capitation rates and rate ranges to account for the Louisiana portion (specific to this contract) of the Contractor's HIPF obligation per the IRS HIPF final fee calculation notice (as noted in 5.17.1.5. above). To calculate the capitation payment adjustment, the DHH will:

5.16.2.3.1. Calculate the HIPF obligation as a percentage of the total data year premiums subject to the HIPF (this total will include all of the first $25 million and 50% of the next $25 million of premium deducted by the IRS). This is the "HIPF%", which is unique to each MCO that is subject to the HIPF.

5.16.2.3.2. Calculate Figure A. Figure A is the total premium revenue for coverage in the Data Year from item 5.17.1.2. above. The Figure A amount has no provision for the HIPF obligation.

5.16.2.3.3. Calculate Figure B. Figure B is the portion of Figure A that is for services subject to the HIPF. Capitation revenue for services that are excludable under Section 9010 of the Patient Protection and Affordable Care Act of 2010, such as long-term care services, will not be included in Figure B. The Figure B amount has no provision for the HIPF obligation.

5.16.2.3.4. Calculate Figure C. Figure C is the calculation of total revenue that incorporates provision for the HIPF and applicable taxes. DHH will use the following formula to calculate Figure C. If the Contractor has not provided satisfactory documentation of federal income tax obligations under section 5.17.1.5., then the Average Federal Income Tax Rate (AvgFIT%) in the formula will be zero. If the Contractor has not provided satisfactory documentation of corporate net income tax obligations under section 5.17.1.6. or if state income taxes are not applicable, then the Average State Income Tax Rate (AvgSIT%) in the formula will be zero. The Louisiana Department of Insurance has determined that state premium tax is not applicable to the HIPF payment; as such, no consideration for premium tax will be made. If in the future, however, the applicability of premium tax to the HIPF payments changes, the formula will be modified accordingly.

Figure B

$$1 - (HIPF\% / (1 - AvgSIT\% - AvgFIT\% \times (1 - AvgSIT\%)))$$

5.16.2.3.5. Calculate Figure D. DHH will calculate Figure D by subtracting Figure B from Figure C. This is the final HIPF adjustment amount that will serve as the basis for DHH payment to the impacted contractors.

5.16.2.3.6. DHH will compare Figure D with Figure B to calculate the percentage adjustment to the Data Year capitation rates and rate ranges for submission to CMS for approval.

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

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

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

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

5.16.7. DHH reserves the right to update the calculation and method of payment for the Annual Fee based upon any new or revised requirements established by CMS in regards to this fee.

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

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

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

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

5.17.2. The CS~~O~~oC Contractor shall be responsible for payment to enrolled providers for the provision of specialized behavioral health services through the last day of

the month which includes the end date of the 1915(c) / 1915(b)(3) segment on the eligibility file.

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

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

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

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

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

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6.0 CORE BENEFITS AND SERVICES

6.1. General Provisions

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

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

6.1.3. Although the MCO shall provide the full range of required core benefits and services listed below in Section 6.1.4, they may choose to provide value-added services over and above those specified when it is cost effective to do so or in the best medical interest of their members. The MCO may offer additional benefits that are outside the scope of core benefits and services to individual members on a case-by-case basis, based on medical necessity, cost-effectiveness, the wishes of the member and/or member's family, the potential for improved health status of the member, and functional necessity. The following departmental priorities may be addressed through value-added services:

- Reduction in Emergency Department (ED) use for non-emergent care through increased access to after-hours care, same-day appointments, data sharing with physicians or hospitals, member education, and/or other interventions identified by the proposer.

- Improved birth outcomes through prenatal, postnatal, and inter-pregnancy care, reduction in early elective deliveries and Cesarean sections, promotion of vaginal birth after Cesarean section (VBAC), and/or other interventions identified by the proposer.

- Improved access to long-acting reversible contraceptives.

- Reduction in childhood obesity through partnerships with pediatricians, education-providers, or nutrition specialists, and/or other interventions identified by the proposer.

- Reduction in health disparities among racial groups in the areas of birth weight, sexually transmitted infections (STIs), and other conditions identified by the proposer through increased access to primary care and/or other interventions identified by the proposer.

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

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

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

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

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

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

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

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

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

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

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

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

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

Pediatric Day Healthcare Services

6.1.5. The MCO shall ensure that services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.

6.1.6. The MCO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the member.

6.1.7. The MCO may place appropriate limits on a service (a) on the basis of certain criteria, such as medical necessity or best practices; or (b) for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

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

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

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

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

6.1.11. The MCO shall not portray core benefits or services as an expanded health benefit.

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

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

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

6.2. Eye Care and Vision Services

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

6.3. Pharmacy Services

6.3.1. Covered Services

6.3.1.1. The MCO must provide coverage for all classes of drugs covered by the Medicaid FFS pharmacy benefit. The MCO may manage coverage and utilization of drugs through the formation of a Formulary or Preferred Drug List. Procedures used to manage utilization may include, but are not limited to, prior authorization, utilization and clinical edits.

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

6.3.1.3. The MCO is not required to enforce the DHH monthly prescription drug quantity limits. However, it may not enact prescription quantity limits more stringent than the Medicaid State Plan.

6.3.2. Formulary

The MCO is required to have a Formulary that follows the minimum requirements below:

6.3.2.1. The Formulary shall be kept up-to-date and available to all providers and members via MCO web site and electronic prescribing tools.

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

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

6.3.2.4. The MCO shall expand its Formulary, as needed, to include newly FDA approved drugs for FDA approved indications, which are deemed to be appropriate, safe, and efficacious in the medical management of members.

6.3.2.5. The Formulary and any revision thereto shall be reviewed and approved by DHH prior to implementation. Any changes to the Formulary shall be submitted to DHH at least 30 days prior to implementation.

6.3.2.6. The Formulary shall include only FDA-approved drug products and certain compounded drugs as deemed appropriate by DHH. For each therapeutic class, the selection of drugs included for each drug class shall be sufficient to ensure enough provider choice and include FDA approved drugs to best serve the medical needs of members with special needs.

6.3.2.7. The MCO shall authorize the provision of a drug not on the Formulary requested by a prescriber on behalf of the enrollee, if the approved prescriber provides relevant clinical information to the MCO to support the medical necessity of the drug, and an explanation as to why a generic alternative or other preferred drug in the same therapeutic category cannot be used. Medically accepted indications shall be consistent with Section 1927(k)(6) of the Social Security Act.

6.3.2.8. The MCO shall have in place a DHH-approved prior approval process for authorizing the dispensing of non-Formulary drugs.

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

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

6.3.3. Preferred Drug List

6.3.3.1. The PDL is a subset of preferred drug products available on the Formulary and an up-to-date version shall be available to all providers and members through the MCO web site and electronic prescribing tools.

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

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

6.3.3.4. The selection of drugs included for each drug class shall be sufficient to ensure enough provider choice and include FDA approved drugs to best serve the medical needs of all enrollees, including those with special needs.

6.3.3.5. The MCO shall authorize the provision of a drug not listed on the PDL requested by a prescriber on behalf of the enrollee, if the approved prescriber provides relevant clinical information to the MCO to support the medical necessity of the drug. Medically accepted indications shall be consistent with Section 1927(k)(6) of the Social Security Act.

6.3.3.6. The MCO shall have in place a DHH-approved prior approval process for authorizing the dispensing of non-PDL drugs.

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

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

6.3.4. Submission and Publication of the Formulary and PDL

6.3.4.1. The MCO shall publish and make available to members and providers upon request a hard copy of the most current Formulary and PDL. Updates to the Formulary or the PDL shall be made available thirty (30) days before the change. The MCO shall prominently post the most current Formulary on its web site.

6.3.4.2. The MCO shall submit an electronic version of its formulary and PDL to DHH at least quarterly. The formulary and PDL must be provided in a format and program approved by DHH, which may include formulary management software commonly used by prescribers.

6.3.5. Pharmaceutical and Therapeutics (P&T) Committee

6.3.5.1. The Contractor shall establish a Pharmaceutical and Therapeutics (P&T) Committee, or similar entity, for the development of the Formulary and the PDL. The Committee shall represent the needs of all its members including enrollees with special needs. Louisiana network physicians, pharmacists, dentists and specialists, including but not limited to a behavioral health specialist, shall have the opportunity to participate in the development of the Formulary, PDL and clinical drug policies and, prior to any changes to the Formulary or PDL, to review, consider and comment on proposed changes. P&T committee meetings shall comply with the Open Meetings Law, La. R.S. 42:12, et seq.

6.3.5.2. The P&T committee shall meet at least semi-annually in Baton Rouge, Louisiana and upon DHH request to consider products in categories recommended for consideration for inclusion/exclusion on the MCO's Formulary or PDL. In developing its recommendations for a Formulary and PDL, the P&T committee shall consider, for each product included in a category of products, the clinical efficacy, safety, cost-effectiveness and any program benefit associated with the product.

6.3.5.3. The MCO shall develop policies governing the conduct of P&T committee meetings, including procedures by which it makes its Formulary and PDL recommendations. P&T Committee meetings shall be open to the public and shall allow for public comment prior to voting by the committee on any change in the preferred drug list or formulary.

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

6.3.6. Behavioral Health Specific Pharmacy Policies and Procedures

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

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

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

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

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

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

~~**6.3.5.4.**~~**6.3.6.6.** Prescription Monitoring Program. The MCO shall require network prescribers to utilize and conduct patient specific queries in the Prescription Monitoring Program (PMP) for behavioral health patients upon writing the first prescription for a controlled substance, then annually. The physician shall print the PMP query and file it as part of the recipient's record. The MCO shall conduct sample audits to verify compliance. Additional PMP queries should be encouraged to be conducted at the prescriber's discretion.

6.4. Behavioral Health Services

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

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

~~**6.4.1.2.**~~ Specialized behavioral health services shall include, but are not limited to services specifically defined in the Medicaid State Plan. Specialized behavioral ~~and provided by psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, mental~~ health services shall also include any other behavioral~~clinics, mental~~ health ~~rehabilitation~~ service subsequently amended into the Medicaid state plan~~providers (public~~ or waivers. Effective December 1, 2015, these~~private). These~~ services are covered by the ~~Statewide Management Organization (SMO) for the Louisiana Behavioral Health Partnership (LBHP).~~

~~**6.4.1.3.**~~

~~**6.4.1.4.**~~**6.4.1.2.** ~~Inpatient~~ MCO for all covered populations except ~~hospital services~~ for ~~acute medical detoxification based on medical necessity are considered medical rather than~~ specialized behavioral~~behavior~~ health services covered by ~~and are~~ the Coordinated System~~responsibility~~ of Care contractor for youth enrolled with the CSoC contractor as per 5.17. ~~the MCO.~~

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

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

6.4.4. Specialized Behavioral Health Covered Services:

- Psychiatrist (all ages)
- Licensed Mental Health Professionals (LMHP)
  - Medical Psychologists
  - Licensed Psychologists
  - Licensed Clinical Social Workers (LCSW)
  - Licensed Professional Counselors (LPC)
  - Licensed Marriage and Family therapists (LMFT)
  - Licensed Addiction Counselors (LAC)

- Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & mental Health, Family Psychiatric & Mental health, or a Certified Nurse Specialist in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric & Mental Health, Child Adolescent Mental Health)

- Mental Health Rehabilitation Services
  - Community Psychiatric Support and Treatment (CPST)
  - Community Psychiatric Support and Treatment (CPST), specialized for high-risk populations. This includes:
    - Multi-Systemic Therapy (MST) (under age 21)
    - Functional Family Therapy (FFT) (under age 21)
    - Homebuilders (under age 21)
    - Assertive Community Treatment (limited to 18 years and older)
  - Psychosocial Rehabilitation (PSR)
  - Crisis Intervention
  - Therapeutic Group Homes (under age 21): Therapeutic Group Homes have a non-Medicaid funded room and board component that must be addressed prior to placement.
  - Crisis Stabilization (under age 21)
- Psychiatric Residential Treatment Facilities (under age 21)
- Inpatient hospitalization (age 21 and under; 65 and older) for Behavioral Health Services
- Outpatient and Residential Substance Use Disorder Services in accordance with the American Society of Addiction Medicine (ASAM) levels of care
- Screening for services including the Coordinated System of Care, may take place while the youth resides in a home and community-based setting and is at risk for hospital levels of care. Screening may also take place while a youth resides in an out-of-home level of care (such as PRTF, SUD residential treatment or TGH) and is preparing for discharge to a home and community-based setting. Screening, up to 90 days prior to discharge from a residential setting is encouraged, as it is expected to assist in comprehensive discharge and treatment planning, prevent disruption, and improve stabilization upon reentry to a home and community environment.
- Pending CMS approval for the coverage of Methadone to treat opiate addiction, the MCOs shall contract with the Opioid Treatment Programs (OTP) for the administration of Methadone and clinical treatment services for members in accordance with state and federal regulations. These services may also be provided via an in lieu of service for other members at the discretion of the MCOs.

6.4.5. Permanent Supportive Housing

6.4.5.1. DHH partners with the Louisiana Housing Authority (LHA) to co-manage the Louisiana Permanent Supportive Housing (PSH) program. PSH provides deeply affordable, community-integrated housing paired with tenancy

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

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

6.4.5.1.2. Assist members in completing the PSH program application;

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

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

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

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

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

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

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

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

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

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

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

~~6.4.2.~~6.4.6. Criteria for screening protocols and determining whether an individual meets the criteria for specialized behavioral health services may be determined by DHH and are based on factors relating to age, diagnosis, disability (acuity) and duration of the behavioral~~mental~~ health ~~illness/~~condition.

~~6.4.3.~~6.4.7. In recognizing that at least 70 percent of behavioral health can be and is treated in the PCP setting, the MCO shall be responsible for the management and provision of all basic behavioral health services including but not limited to those with mild, moderate depression, ADHD, generalized anxiety, etc. that can be appropriately screened, diagnosed or treated in a primary care setting. MCO support shall include but not be limited to assistance which will align their practices with best practice standards, such as those developed by the American Academy of Pediatrics, for the assessment, diagnosis, and treatment of ADHD, such as increasing the accuracy of ADHD diagnosis, increasing screening for other behavioral health concerns, and increasing the use of behavioral therapy as first-line treatment for children under age 6.

~~6.4.4.~~6.4.8. The MCO is responsible for the provision of screening, prevention, early intervention and referral services including screening services as defined in the EPSDT benefit (The EPSDT benefit guarantees coverage of "screening services" which must, at a minimum, include "a comprehensive health and developmental history – including assessment of both physical and mental health.) Section 1905(r)(1)(B)(i) of the Social Security Act, 42 U.S.C. §1396d(r)(1)(B)(i))

~~6.4.5.~~6.4.9. The MCO shall provide guidelines, education and training, and consultation to PCPs to support the provision of basic behavioral health services in the primary care setting.

~~6.4.5.1.~~ The MCO shall ensure network providers utilize behavioral health screening tools and protocols consistent with industry standards.

~~6.4.5.2.~~ The MCO ~~and PCP~~ shall work to increase screening in primary care for developmental, behavioral, and social delays, as well as screening for child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO may provide technical assistance to providers, incentives, or other means to increase screening for ~~collaborate with~~ behavioral health needs in primary care~~specialists, including but not limited to, psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, mental health clinics, mental health rehabilitation service providers (public or private), and other specialty behavioral health providers,~~

~~to ensure the provision of services to members as specified in the Medicaid State Plan~~.

~~6.4.5.3.~~6.4.9.1. ~~The MCO may facilitate the utilization and reimbursement of mental health counselors, such as bachelors or masters level social workers to assist in screening, patient education and low level counseling in the PCP setting. The MCO should work with the SMO to further opportunities for integrating behavioral health services in the primary care setting including the co-location of mental health and primary care providers.~~

6.4.9.2. ~~The MCO shall~~ The MCO shall work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for developmental, behavioral, and social delays, as well as child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO shall work to increase the percentage of children with positive screens who 1) receive a warm handoff to and/or are referred for more specialized assessment(s) or treatment and 2) receive specialized assessment or treatment.

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

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

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

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

6.4.11.2. Processes and protocols for screening and referral;

6.4.11.3. Network Development for services and supports;

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

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

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

6.4.11.7. Program monitoring and quality improvement; and

~~5.1.2.~~ Timelines required for implementation.~~strongly support the integration of both physical and behavioral health services. Additional requirements for coordination and integration of primary and behavioral health care are provided in the Section 6.33 Continuity for Behavioral Health Care.~~

~~6.4.5.4.~~6.4.11.8.

6.5. Laboratory and Radiological Services

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

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

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

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

6.6. EPSDT Well Child Visits

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

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

6.6.3. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) mandates **that all medically necessary services** listed in Section 1905(a) of the Social Security Act be covered under Medicaid for the EPSDT program provided for Medicaid eligible individuals under the age of 21 (42 CFR 441, Subpart B). The MCO is

responsible to provide **all medically necessary services whether specified in the core benefits and services and Louisiana Medicaid State Plan or not**, except those services (carved out/excluded/prohibited services) that have been identified in this RFP and the Contract.

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

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

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

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

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

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

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

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

6.7. Immunizations

6.7.1. The MCO shall provide all members under twenty-one (21) years of age with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.

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

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

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

~~6.7.4.~~**6.7.5.** The MCO shall provide all members twenty-one (21) years of age and older with all vaccines and immunizations in accordance with State Plan services as identified at: http://www.lamedicaid.com/provweb1/fee_schedules/Immune_FS_Adults_6.pdf

6.8. Emergency Medical Services and Post Stabilization Services

6.8.1. Emergency Medical Services

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

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

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

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

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

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

6.8.1.7. The MCO will include in the proposal a plan to provide care in the most appropriate and cost-effective setting. The plan should specifically address non-emergent use of hospital Emergency Departments. Strategies of interest to DHH include but are not limited to access to primary care services through

medical homes, urgent care and retail clinics; and, interventions targeted to super-utilizers, such as patients with sickle cell disease, chronic pain, dental, and/or behavioral health conditions.

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

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

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

6.8.2. Post Stabilization Services

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

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

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

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

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

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

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

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

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

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

6.8.2.2.4. The member is discharged.

6.9. Emergency Ancillary Services Provided at the Hospital

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

6.10. Sexually Transmitted Infection (STI) Prevention

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

6.11. Prenatal Care Services

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

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

6.11.3. The MCO shall perform or require health providers to perform a risk assessment on all obstetrical patients including a screen for tobacco, alcohol, and substance use and have available, accessible, and adequate maternal fetal medicine

specialists for high-risk obstetrical patients requiring further evaluation, consultation, or care and delivery as recommended by the guidelines of the American College of Obstetricians and Gynecologists. A pregnant woman is considered high-risk if one or more risk factors are indicated. The MCO shall provide case management for high-risk obstetrical patients including, but not limited to, patients with a history of prior preterm birth.

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

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

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

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

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

6.12. Maternity Services

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

6.13. Perinatal Services

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

6.13.1.1. Routine cervical length assessments for pregnant women;

6.13.1.2. Provision of injectable or vaginal progesterone for every eligible pregnant woman with a history of pre-term labor or a short cervix found in the current pregnancy. The MCO shall not require prior authorization of progesterone

for the prevention of premature birth unless written approval from the Medicaid Medical Director is obtained. The MCO will provide progesterone access to eligible members in a timely fashion.

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

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

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

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

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

6.14. Family Planning Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.15. Hysterectomies

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

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

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

6.15.2.2. The individual or her representative, if any, must sign and date the **Acknowledgment of Receipt of Hysterectomy Information** form (See

Appendix L) prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age.

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

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

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

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

6.16. Sterilization

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

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

6.17. Limitations on Abortions

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

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

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

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

6.17.3. For abortion services performed because of Section 6.16.2.1, a physician must certify in their handwriting, that on the basis of their professional judgment, the

life of the pregnant woman would be endangered if the fetus were carried to term. The provider shall:

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

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

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

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

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

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

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

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

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

6.18. Institutional Long-Term Care Facilities/Nursing Homes

~~**5.1.3.** The MCO is not responsible for any institutional long-term care facility/nursing home services. All such services shall continue to be reimbursed as fee-for-service. Any MCO member transitioned to a nursing home level of care will be disenrolled from the MCO at the earliest effective date allowed by system edits.~~

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

6.19. ~~Medical~~ Services for Special Populations

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

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

6.19.1.2. Individuals with intravenous drug use;

6.19.1.3. Pregnant women with substance use disorders or co-occurring disorders;

~~**6.19.1.1.**~~**6.19.1.4.** Substance using women with dependent children;

6.19.1.5. Children with behavioral health needs in contact with other child serving systems who are not eligible for CSoC;

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

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

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

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

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

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

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

~~**6.19.3.3.**~~**6.19.3.4.** Members may be identified by DHH and that information provided to the MCO.

6.19.4. Individualized Treatment Plans and Care Plans

All SHCN members shall be referred for, and if found eligible, offered case management, including an individualized treatment plan or a person-centered plan of care.

The individualized treatment plans must be:

~~6.19.3.4.~~6.19.4.1. Developed by the member's primary care provider and/or other lead provider as appropriate~~PCP~~, with member participation, and in consultation with any specialists caring for the member;

~~6.19.3.5.~~6.19.4.2. Approved by the MCO in a timely manner, as defined and required by the MCO; and

~~6.19.3.6.~~6.19.4.3. In compliance with applicable quality assurance and utilization management standards.

6.19.4.4. SHCN members identified in 6.19.1.6 and 6.19.1.7 must have a **person-centered plan of care** that serves as the basis of service authorization for specialized behavioral health services and is thus inclusive of all treatment plan elements requiring authorization.

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

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

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

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

6.22. Preventative and Safety Educational Programs/Activities

The MCO may provide healthy lifestyle educational programs/activities for the whole family which may include, for example, a discount to a local fitness facility, web access to a healthy cooking website, weight management program participation and/or a smoking cessation program. The MCO shall obtain approval from DHH prior to implementation of any such program.

6.23. Medical Transportation Services

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

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

6.23.2.1. NEMT shall be provided to and from all medically necessary Medicaid state plan services (including carved out services) for those members who lack viable alternate means of transportation.

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

- Transportation for the member and one attendant, by ambulance, taxicab, airplane, bus, or other appropriate means; and
- For trips requiring long distance travel, in accordance with Section 6.23.2.3, the cost of meals and lodging and other related travel expenses determined to be necessary to secure medical examinations and treatment for a member.

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

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

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

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

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

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

6.23.2.5.1. For all NEMT services requiring scheduling and/or prior authorization, the MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of the

request for services. All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service or no less than 24 hours prior to the date of service, unless the request is received less than 48 hours prior to service.

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

~~**6.23.2.3.4.**~~**6.23.2.5.3.** Expedited service authorizations for services that are deemed urgent but not emergent, shall be determined as expeditiously as the member's health condition requires. For NEMT ambulance services the timeframe for approval must allow ambulance providers to comply with any local ordinances governing their response times.

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

6.24. Excluded Services

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

6.24.1.1. Applied Behavior~~Behavioral~~ Analysis;

6.24.1.2. Medical Dental with the exception of the EPSDT varnishes provided in a primary care setting;

6.24.1.3. ICF/DD Services;

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

6.24.1.5. Nursing Facility Services;

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

6.24.1.7. All Home & Community-Based Waiver ~~-~~Services~~,~~;

~~**5.1.3.1.** Specialized Behavioral Health Services;~~

6.24.1.8. Targeted Case Management Services; and

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

6.25. Prohibited Services

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

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

6.25.3. Elective cosmetic surgery, and

6.25.4. Services for treatment of infertility.

6.26. Expanded Services/Benefits

6.26.1. As permitted under 42 CFR §438.6(e),the MCO may offer expanded services and benefits to enrolled Medicaid MCO members in addition to those core benefits and services specified in this RFP.

6.26.2. These expanded services may include health care services which are currently non-covered services by the Louisiana Medicaid State Plan and/or which are in excess of the amount, duration, and scope in the Louisiana Medicaid State Plan.

6.26.3. These services/benefits shall be specifically defined by the MCO in regard to amount, duration and scope. DHH will not provide any additional reimbursement for these services/benefits.

6.26.4. Transportation for these services/benefits is the responsibility of the member and/or MCO, at the discretion of the MCO.

6.26.5. The MCO shall provide DHH a description of the expanded services/benefits to be offered by the MCO for approval. Additions, deletions or modifications to expanded services/benefits made during the contract period must be submitted to DHH, for approval.

6.26.6. Examples of expanded services/benefits include, but are not limited to:

6.26.6.1. All vaccines and immunizations in accordance with the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) for members over twenty-one (21) years of age, not otherwise covered in Section 6.7.5;

6.26.6.2. Tooth extractions or dental services;

6.26.6.3. Eyeglasses for adults;

6.26.6.4. Pain management services;

6.26.6.5. Community health workers; and

6.26.6.6. Sickle cell day hospitals.

6.26.7. DHH may expand, eliminate, or otherwise change core benefits and services. If changed, the Contract shall be amended and the MCO given sixty (60) days advance notice whenever possible.

6.27. Care Management

6.27.1. Care management is defined as the overall system of medical management, care coordination, continuity of care, care transition, chronic care management, and independent review. The MCO shall ensure that each member has an ongoing source of primary and/or behavioral healthcare~~care~~ appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating Medicaid covered services provided to the member.

6.27.2. The MCO shall be responsible for ensuring:

6.27.2.1. Member's health care needs and services/care are planned and coordinated through the MCO PCP and/or behavioral health provider~~;~~

6.27.2.2. Accessibility of services and promoting prevention through qualified providers and medical home practices in accordance with 42 CFR §438.6(k) which requires the provision for reasonable and adequate hours of operation including 24 hour availability of information, referral, and treatment for emergency medical conditions; and

6.27.2.3. Care coordination and referral activities, in person or telephonically depending on member's acuity, incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical services and coordination for members requiring behavioral health services ~~with the Louisiana Behavioral Health Partnership~~.

6.27.2.4. Patients with a condition that causes chronic pain and have five (5) or more ED visits in the most recent 12-month period for chief complaint of pain are contacted by the MCO for a pain management plan and this plan will be shared with the patients' PCP, the patient, and relevant ED staff.

6.28. Referral System for Specialty Healthcare

6.28.1. The MCO shall have a referral system for MCO members requiring specialty health care services to ensure that services can be furnished to enrollees promptly and without compromise to care. The MCO shall provide the coordination necessary for referral of MCO members to specialty providers. The MCO shall assist the provider or member in determining the need for services outside the MCO network and refer the member to the appropriate service provider. The referral system must include processes to ensure monitoring and documentation of specialty health care and out-of-network referrals, services (*e.g.*, medications prescribed, treatment received, recommendations for care), and follow up are included in the PCP's member medical record.

6.28.2. The MCO shall submit referral system policies and procedures for review and approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions. Referral policies and procedures shall describe referral systems and guidelines and, at a minimum, include the following elements:

6.28.2.1. When a referral from the member's PCP is and is not required (See Section 8.5.1.6 Exceptions to Service Authorization and/or Referral Requirements);

6.28.2.2. Process for member referral to an out-of-network provider when there is no provider within the MCO's provider network who has the appropriate training or expertise to meet the particular health needs of the member;

6.28.2.3. Process for providing a standing referral when a member with a condition requires on-going care from a specialist;

6.28.2.4. Process for referral to specialty care for a member with a life-threatening condition or disease who requires specialized medical care over a prolonged period of time;

6.28.2.5. Process for member referral for case management;

6.28.2.6. Process for member referral for chronic care management;

6.28.2.7. Policy that prohibits providers from making referrals for designated health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship.

6.28.2.8. Processes to ensure monitoring and documentation of specialty health care services and follow up are included in the PCP's member medical record.

6.28.2.9. There must be written evidence of the communication of the patient results/information to the referring physician by the specialty health care provider or continued communication of patient information between the specialty health care provider and the primary care provider; and

6.28.2.10. Process for referral of members for Medicaid State Plan services that are excluded from MCO core benefits and services and that will continue to be provided through fee-for-service Medicaid.

6.28.2.11. The MCO shall develop electronic, web-based referral processes and systems.

6.29. Care Coordination, Continuity of Care, and Care Transition

The MCO shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to MCO members. The MCO shall establish a process to coordinate the delivery of core benefits and services with services that are reimbursed on a fee-for-service basis by DHH or DHH's dental benefit program manager. The MCO shall ensure member-appropriate providerPCP choice within the MCO and interaction with providers outside the MCO. Continuity of care activities shall ensure that the appropriate personnel, including the service providersPCP, are kept informed

of the member's treatment needs, changes, progress or problems. These MCO activities and processes shall be demonstrated via workflows with specific decision points and provided to DHH by January 11, 2016.

Continuity of care activities shall provide processes by which MCO members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The MCO shall ensure that service delivery is properly monitored through member surveys, medical and treatment record reviews, and EOBs to identify and overcome barriers to primary and preventive care that an MCO member may encounter. Corrective action shall be undertaken by the MCO on an as needed basis and as determined by DHH.

6.29.1. The MCO shall be responsible for the coordination and continuity of care of healthcare services for all members consistent with 42 CFR §438.208. In addition, the MCO shall be responsible for coordinating with the Office of Citizens with Developmental Disabilities for the behavioral health needs of the I/DD co-occurring population.

6.29.2. The MCO shall implement DHH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements:

6.29.2.1. Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;

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

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

6.29.2.4. Coordinate MCO provided services with services the member may receive from other health care providers;

6.29.2.5. Share with other health care entities serving the member with special health care needs the results and identification and assessment of that member's needs to prevent duplication of those activities;

6.29.2.6. Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164, and other applicable state or federal laws;

6.29.2.7. Maintain and operate a formalized hospital and/or institutional discharge planning program;

6.29.2.8. Coordinate hospital and/or institutional discharge planning that includes post-discharge care as appropriate, including aftercare appointments, following an inpatient, PRTF, or other out-of-home stay and~~;~~ assure that prior authorization for prescription coverage is addressed and or initiated before patient discharge. The MCO must have policies and procedures requiring and assuring that:~~;~~

6.29.2.8.1. Behavioral health pharmacy prior authorization decisions are rendered before a member is discharged from a behavioral health

facility (including, but not limited to, inpatient psychiatric facilities, PRTF's, and residential substance use disorder settings).

6.29.2.8.2. Care managers follow-up with members with a behavioral health-related diagnosis within 72 hours following discharge.

6.29.2.8.3. Coordination with DHH and other state agencies following an inpatient, PRTF, or other residential stay for members with a primary behavioral health diagnosis occurs timely when the member is not to return home.

6.29.2.9. Document authorized referrals in its utilization management system; and

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

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

6.29.2.12. For the behavioral health population, provide aftercare planning for members prior to discharge from a 24-hour facility.

6.30. Referrals for Tobacco Cessation and Problem Gaming

6.30.1 MCO Care Managers shall screen for problem gaming and tobacco usage of each member during the initial individual needs assessment. The CM shall be responsible for advising members that screen positive to quit and will refer the member to appropriate network providers offering tobacco cessation treatment and/or problem gaming services.

6.30.2 Information regarding treatment services and/or referral to care shall be entered into the MCO's systems for the purpose of tracking and reporting according to various demographics (e.g., age, race, gender, behavioral health diagnosis, etc.). Tobacco cessation and problem gaming reports shall be made available upon DHH request in a format and frequency as determined by DHH.

~~6.30.1~~6.30.3 The MCO shall collect and report the information associated with tobacco cessation and/or problem gaming screening, treatment and referral information as appropriate and as specified in the Behavioral Health Companion Guide.

~~6.30.~~6.31. Continuity of Care for Pregnant Women

~~6.30.1.~~6.31.1. In the event a member entering the MCO is receiving medically necessary covered services in addition to, or other than, prenatal services (see below for new enrollees receiving only prenatal services) the day before MCO enrollment, the MCO shall be responsible for the costs of continuation of such medically

necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The MCO shall provide continuation of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The MCO may require prior authorization for continuation of the services beyond thirty (30) calendar days, however the MCO is prohibited from denying authorization solely on the basis that the provider is non-contract provider.

~~6.30.2.~~6.31.2. In the event a member entering the MCO is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before MCO enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider until such time as the MCO can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health.

~~6.30.3.~~6.31.3. In the event a member entering the MCO is in her second or third trimester of pregnancy and is receiving medically-necessary covered prenatal care services the day before enrollment, the MCO shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract provider) for sixty (60) days post-partum, provided the member is still eligible for Medicaid, or referral to a safety net provider if the member's eligibility terminates before the end of the post-partum period.

~~6.30.4.~~6.31.4. The contract shall ensure that the member is held harmless by the provider for the costs of medically necessary core benefits and services.

~~6.31.~~6.32. Preconception/Inter-conception Care

For fertile women of reproductive age, the woman's plan for future pregnancy shall be discussed on an annual basis during routine gynecological care, with special counseling on pregnancy prevention options for adolescent patients. Appropriate family planning and/or health services shall be provided based on the patient's desire for future pregnancy and shall assist the patient in achieving her plan with optimization of health status in the interim. Use of long acting reversible contraceptives should be encouraged and barriers such as prior authorization shall not be required for approval.

~~6.32.~~6.33. Continuity of Care for Individuals with Special Health Care Needs

In the event a Medicaid or CHIP eligible entering the MCO is receiving medically necessary covered services, the day before MCO enrollment, the MCO shall provide continuation/coordination of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The MCO may require prior authorization for continuation of the services beyond thirty (30) calendar days; however the MCO is prohibited from denying authorization solely on the basis that the provider is non-contract provider.

~~6.33.~~6.34. Continuity of Care for Pharmacy Services

~~6.33.1.~~6.34.1. The MCO must submit for approval, a transition of care program that ensures members can continue treatment of maintenance medications for at least 60 days after launch of pharmacy services, ~~or~~ enrollment into the MCO's plan, or switching from one plan to another. The MCO shall continue any treatment of antidepressants and antipsychotics for at least 90~~60~~ days after enrollment into the MCO's plan. Additionally, an enrollee that is, at the time of enrollment~~,~~ into the MCO, receiving a prescription drug that is not on the MCO's Formulary or PDL shall be permitted to continue to receive that prescription drug if medically necessary for at least 60 days.

~~6.33.2.~~6.34.2. The MCO shall continue the behavioral health therapeutic classes (including long-acting injectable antipsychotics), and other medication assisted treatment (including Suboxone and naloxone) ~~medication~~ prescribed to the enrollee in a state mental health treatment facility for at least 90~~60~~ days ~~after~~ the facility discharges the enrollee, unless the MCO's psychiatrist, in consultation and agreement with the facility's prescribing physician, determines that the medications are:

- Not medically *necessary; or*
- *Potentially harmful to the enrollee.*

~~6.34.~~6.35. Continuity for Behavioral Health Care

~~6.34.1.~~6.35.1. The PCP shall provide basic behavioral health services (as described previously in this Section) and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.

~~6.34.2.~~6.35.2. The MCO shall establish policies and procedures~~a formal memorandum of understanding with the SMO, effective the begin date of the contract,~~ to facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs.

Principles that guide care integration are as follows:

- Mental illness and addiction are healthcare issues and must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings;
- Many people suffer from both mental illness and addiction. As care is provided, both illnesses must be understood, identified, and treated as primary conditions;
- The system of care will be accessible and comprehensive, and will fully integrate an array of prevention and treatment services for all age groups. It will be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement;
- It is important that relevant clinical information is accessible to both the primary care and behavioral health providers consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy.

~~5.1.4. In order to ensure continuity and coordination of care for members who have been determined by a medical provider to need specialized behavioral health services or who may require inpatient/outpatient behavioral health services, the MCO shall be responsible for referring to the SMO.~~

~~6.34.3.~~6.35.3. In any instance when the member presents to the network provider, including calling the MCO's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the MCO shall instruct the member to seek help from the nearest emergency medical provider. The MCO shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed. ~~Payment for the emergency service is the responsibility of the MCO, payment for any follow-up care is the responsibility of the SMO.~~

~~6.34.4.~~6.35.4. The MCO shall comply with all post-stabilization care service requirements found at 42 CFR §422.113.

~~6.34.5.~~6.35.5. The MCO shall include documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health and primary care provider.

~~6.34.6.~~6.35.6. The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity, as well as, cost-effectiveness of care.

~~6.34.7.~~6.35.7. These procedures must address members with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services.

~~6.34.8.~~6.35.8. The MCO shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures.

~~6.34.9.~~6.35.9. The MCO shall work ~~with the SMO~~ to strongly support the integration of both physical and behavioral health services through:

~~6.34.9.1.1.~~6.35.9.1.1. Enhanced detection and treatment of behavioral health disorders in primary care settings;

~~6.34.9.1.2.~~6.35.9.1.2. Coordination of care for members with both medical and behavioral health disorders, including promotion of care transition between inpatient services and outpatient care for members with co-existing medical-behavioral health disorders;

~~6.34.9.1.3.~~6.35.9.1.3. Assisting members without a diagnosed behavioral health disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medical disorder;

~~6.34.9.1.4.~~6.35.9.1.4. Utilization of approved communication and consultation by PCPs with behavioral health providers of co-enrolled members with

co-existing medical and behavioral health disorders requiring co-management.

6.35.9.1.5. Develop capacity for enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients.

~~6.34.9.1.5.~~6.35.9.1.6. Distributing Release of Information forms as per 42 CFR §431.306, and provide training to MCO providers on its use.

~~6.34.9.1.6.~~6.35.9.1.7. Educating MCO members and providers regarding appropriate utilization of emergency room (ER) services, including referral ~~through the SMO~~ to community behavioral health specialists for behavioral health emergencies, as appropriate;

~~6.34.9.1.7.~~6.35.9.1.8. Identifying those~~shared members (i.e., those members receiving both Bayou Health managed primary medical care and SMO-managed specialty behavioral healthcare)~~ who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate ~~SMO~~ contracted behavioral health specialists;

~~5.1.4.1.1. Tracking names of shared members who visit ED/ER, generate and distribute monthly reports to the SMO that include names of members and dates of service;~~

~~6.34.9.1.8.~~6.35.9.1.9. Ensuring~~ through referral to the SMO,~~ continuity and coordination of care for members who have been screened positive or determined as having need of specialized medical health services or who may require inpatient/outpatient medical health services. These activities must include referral and follow-up for member(s) requiring behavioral health services. ~~An approved "SMO and Bayou Healthcare Plan Coordination of Care" referral form should be used;~~

~~6.34.9.1.9.~~6.35.9.1.10. Documenting authorized referrals in the MCO's clinical management system;

~~6.34.9.1.10.~~6.35.9.1.11. Developing capacity for enhanced rates or incentives for integrated care by providers;

~~6.34.9.1.11.~~6.35.9.1.12. Providing or arranging for training of MCO providers and Care Managers on identification and screening of behavioral health conditions and referral procedures;

~~6.34.9.1.12.~~6.35.9.1.13. Conducting Case Management rounds at least monthly with the Behavioral Health Case Management team~~SMO~~; and

~~6.34.9.1.13.~~6.35.9.1.14. Participating in regular collaborative meetings at least yearly or as needed, with~~which include the SMO, and~~ DHH representatives for the purpose of coordination and communication.

~~6.35.~~6.36. Continuity for DME, Prosthetics, Orthotics, and Certain Supplies

In the event a Medicaid member entering the MCO is receiving Medicaid covered durable medical equipment, prosthetics, orthotics, and certain supplies services the day before MCO enrollment, whether such services were provided by another MCO or Medicaid fee-for-service, the MCO shall be responsible for the costs of continuation of these services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The MCO shall provide continuation of such services for up to ninety (90) calendar days **or** until the member may be reasonably transferred (within timeframe specified in this RFP) without disruption, whichever is less. The MCO must also honor any prior authorization for durable medical equipment, prosthetics, orthotics and certain supplies services issued while the member was enrolled in another MCO or the Medicaid fee-for-service program for a period of ninety (90) calendar days after the member's enrollment in the MCO.

~~6.36.~~6.37. Care Transition

~~6.36.1.~~6.37.1. The MCO shall provide active assistance to members when transitioning to another MCO or to Medicaid FFS.

~~6.36.2.~~6.37.2. The receiving MCO shall be responsible for the provision of medically necessary services covered under the Contract that are required for the member during the transition period (i.e. prenatal care, acute care, etc.). The transition period shall not exceed thirty (30) calendar days from the effective date of the member's enrollment in the receiving MCO unless the member has been identified as an individual with special health care needs (See Section 6.32 for exceptions for individuals with Special Health Care Needs.) During this transition period, the receiving MCO shall be responsible for, but not limited to, notification to the new PCP of member's selection, initiation of the request of transfer for the member's medical files, arrangement of medically necessary services (if applicable) and all other requirements for new members.

~~6.36.3.~~6.37.3. If a member is to be transferred between MCOs but is hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving MCO. However, the relinquishing MCO is responsible for the member's hospitalization until the member is discharged. The receiving MCO is responsible for all other care.

~~6.36.4.~~6.37.4. Upon notification of the member's transfer, the receiving MCO shall request copies of the member's medical record, unless the member has arranged for the transfer. The previous provider shall transfer a copy of the member's complete medical record and allow the receiving MCO access (immediately upon request) to all medical information necessary for the care of that member. Transfer of records shall not interfere or cause delay in the provision of services to the member. The cost of reproducing and forwarding medical records to the receiving MCO shall be the responsibility of the relinquishing MCO. A copy of the member's medical record and supporting documentation shall be forwarded by the relinquishing MCO's PCP within ten (10) business days of the receiving MCO's PCP's request.

~~6.36.4.1.~~6.37.4.1. The MCO shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into

the MCO, regardless of whether such services are provided by an in-network or out-of-network provider, however, the MCO may require prior authorization of services beyond thirty (30) calendar days.

~~6.36.4.2.~~6.37.4.2. During transition the MCO is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider.

~~6.36.5.~~6.37.5. Appropriate medical records and case management files of the transitioning member shall also be transmitted. The cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor.

~~6.36.6.~~6.37.6. Special consideration shall be given to, but not limited to, the following:

~~6.36.6.1.~~6.37.6.1. Members with significant conditions or treatments such as enteral feedings, oxygen, wound care, and ventilators, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition;

~~6.36.6.2.~~6.37.6.2. Members who have received prior authorization for services such as scheduled surgeries, post-surgical follow up visits, therapies to be provided after transition or out-of-area specialty services;

~~6.36.6.3.~~6.37.6.3. Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the NICU after birth;

~~6.36.6.4.~~6.37.6.4. Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the last 30 days, the need for organ or tissue transplantation, chronic illness resulting in hospitalization;

~~6.36.7.~~6.37.7. When relinquishing members, the MCO is responsible for timely notification to the receiving MCO regarding pertinent information related to any special needs of transitioning members. The MCO, when receiving a transitioning member with special needs, is responsible to coordinate care with the relinquishing Contractor so services are not interrupted, and for providing the new member with MCO and service information, emergency numbers and instructions on how to obtain services.

6.37.8. Transition of Care for Integration of Specialized Behavioral Health

6.37.8.1. For the period December 1, 2015 through February 29, 2016 the MCO shall honor all Magellan authorization decisions for outpatient services at the level of service and duration approved prior to December 1, 2015. The MCO must continue to honor existing Magellan authorizations beyond February 29, 2016 until such time as a determination for continued services is complete and the member and provider have been timely notified. These requirements apply to all prior approvals regardless of the provider's status as a contracted or non-contracted provider.

~~6.37.~~6.38. **Case Management**

~~6.37.1.~~6.38.1. The MCO shall develop and implement a case management program through a process which provides that appropriate and, medically-related services, social services, and basic and specialized behavioral health services are identified, planned, obtained and monitored for identified members who are high risk or have unique, chronic, or complex needs. The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon appropriate plan that meets the medical, functional, social and behavioral health needs of the member. The MCO shall submit case management program policies and procedures to DHH for approval within thirty (30) days following the date the contract is signed and annually thereafter.

~~6.37.2.~~6.38.2. Case Management program functions shall include but not be limited to:

~~6.37.2.1.~~6.38.2.1. Early identification, through active outreach, of members who have or may have special needs;

~~6.37.2.2.~~6.38.2.2. Assessment of a member's risk factors;

~~6.37.2.3.~~6.38.2.3. Education regarding patient-centered medical home and referral to a medical home when appropriate;

~~6.37.2.4.~~6.38.2.4. Development of an individualized treatment plan, in accordance with Section 6.1918.4;~~.~~;

~~6.37.2.5.~~6.38.2.5. Referrals and assistance to ensure timely access to providers;

~~6.37.2.6.~~6.38.2.6. Care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed;

~~6.37.2.7.~~6.38.2.7. Monitoring;

~~6.37.2.8.~~6.38.2.8. Continuity of care; and

~~6.37.2.9.~~6.38.2.9. Follow-up and documentation.

6.38.3. Additional Case Management Requirements for the SHCN populations with behavioral health needs as defined in 6.19.

A Plan of Care shall be developed by the MCO for this population annually at a minimum and as needed. The plan of care shall list all services and intensity of those services appropriate for the individual. The POC serves as the basis of service authorization and shall be inclusive of all treatment plan elements requiring authorization by the MCO. The POC shall be integrated and shall identify both physical and behavioral service needs. Additionally, the POC shall include natural supports needed and referrals to other services.

6.38.3.1. The MCO shall:

- Ensure level of care evaluations/reevaluations and plans of care are developed timely and appropriately;

- Ensure plans of care address members' assessed needs, health and safety risk factors, and personal goals and are consistent with the evaluation/assessment;
- Ensure members are referred to service providers in accordance with freedom of choice requirement;
- Ensure members receive services in accordance with their approved plan of care, including the type, scope, amount, duration, and frequency; and
- Conduct timely follow-up with members who miss appointments or who are discharged from a 24-hour facility.

6.38.4. Assessments for Mental Health Rehabilitation Services for adults:

6.38.4.1. The MCO shall be responsible for conducting or subcontracting to conduct assessments as per the requirements in the State Plan. DHH will establish process measures to monitor access to timely assessments.

6.38.4.2. Assessment for eligibility shall be completed within fourteen (14) calendar days of referral.

6.38.4.3. Annual recertification for services will be completed within 365 days of most recent certification in order to assure that there is no lapse in service authorization or services to members who remain qualified.

6.38.4.4. The MCO shall make service authorizations within five (5) business days following completion of the assessment/recertification.

6.38.5. Independent Evaluations for PASRR Level II

6.38.5.1. The MCO shall be responsible for conducting or subcontracting to conduct PASRR Level II evaluations of members upon referral from OBH. Referrals will be based upon the need for an independent evaluation to determine the need for nursing facility services and/ or the need for specialized services to address mental health issues while the member is in a nursing facility.

6.38.5.2. In conducting the evaluation, the MCO shall follow the criteria set forth in 42 CFR §483.128 and shall utilize the PASRR Level II standardized evaluation form provided by DHH.

6.38.5.3. Evaluators may use relevant evaluative data, obtained prior to initiation of PASRR, if the data are considered valid and accurate and reflect the current functional status of the individual. However, if necessary to supplement and verify the currency and accuracy of existing data, the evaluator shall gather additional information necessary to assess proper placement and treatment.

6.38.5.4. In order to comply with federally mandated timelines, the MCO shall submit the completed Level II evaluation report to OBH within four (4) calendar days of receipt of the referral from OBH.

6.38.5.5. Level II evaluation recommendations shall focus on ensuring the least restrictive setting appropriate with the appropriate services.

6.38.5.6. When OBH determines that nursing facility services are not appropriate, the MCO shall assist eligible members to obtain appropriate alternative behavioral health services available under this contract.

6.38.5.7. If at any time the MCO should become aware that a member residing in a nursing home who has an SMI has not received a Level II determination, the MCO shall notify OBH.

6.38.5.8. The MCO shall notify OBH as per the Behavioral Health Companion Guide of any problems or issues with the PASRR process.

6.38.6. Case Management for Members Receiving Nursing Facility Care

6.38.6.1. The MCO shall ensure that members who are identified by OBH as needing specialized services for behavioral health while in a nursing facility have access to such services as required under 42 CFR §483.120 and ~~as~~ determined by OBH.

6.38.6.2. The MCO shall have a person centered plan of care completed within 30 days from the OBH PASRR Level II determination. Service authorizations for specialized behavioral health services must be in place within 15 days following the completion of the plan of care.

6.38.6.3. The MCO shall inform OBH of any changes in condition of members residing in a nursing facility that would require a resident review as noted in Section 1919(e)(7)(B)(iii) of the Social Security Act.

6.38.7. PASRR Tracking

6.38.7.1. The MCO shall utilize the Behavioral Health Companion Guide to report utilization of the PASRR process.

~~**6.37.2.10.**~~**6.38.7.2.** The MCO is responsible for tracking for members residing in a nursing facility who went through the PASRR process, those identified with SMI and those receiving specialized services as per 42 CFR §483.130.

~~**6.37.2.11.**~~**6.38.7.3.** The MCO shall track and report quarterly to OBH the delivery of all PASRR specialized behavioral health services as defined and required under 42 CFR §483.120.

6.38.7.4. The MCO shall advise OBH and Medicaid on any barriers to completing the PASRR evaluations or tracking process.

6.38.7.5. Records shall be retained for 5 years in order to support OBH determinations, and to protect the individual's appeal rights as per 42 CFR §483.130.

~~6.38.~~6.39. Case Management Policies and Procedures

The MCO shall submit Case Management Program policies and procedures to DHH for approval within thirty (30) days from the date the Contract is signed by the MCO, annually and prior to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements:

6.39.1. A process to offer voluntary participation in the Case Management Program to eligible members;

6.39.2. Identification criteria, process, and triggers for referral and admission into the Case Management Program;

6.39.3. Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, the following:

6.39.3.1. Reproductive aged women with a history of prior poor birth outcomes; and

6.39.3.2. High risk pregnant women.

6.39.4. The provision of an individual needs assessment and diagnostic assessment; the development of an individual plan of~~treatment~~ care and treatment plan, as necessary, based on the needs assessment; the establishment of short and long term treatment objectives; the monitoring of outcomes; and a process to ensure that treatment care plans are revised as necessary. These procedures shall be designed to accommodate the specific cultural and linguistic needs of the MCO's members; Procedures must describe collaboration processes with member's treatment providers;

6.39.5. A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;

6.39.6. Procedures and criteria for making referrals to specialists and subspecialists~~;~~

6.39.7. Procedures and criteria for maintaining care plans and referral services when the member changes PCPs and behavioral health providers; and

6.39.8. Coordination of Case Management activities for members also receiving services through the MCO's Chronic Care Management Program.

~~**6.39.9.** Procedures to ensure case management services are conflict-free.~~

6.40. Case Management Reporting Requirements

The MCO shall submit case management reports quarterly with an annual summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports. The case management reports shall include at a minimum:

6.40.1. Number of members identified with potential special healthcare needs utilizing historical claims data;

6.40.2. Number of members with potential special healthcare needs identified by the member's PCP and/or behavioral health provider;

6.40.3. Number of members identified with potential special healthcare needs that self-refer;

6.40.4. Number of members with potential special healthcare needs identified by the MCO;

6.40.5. Number of members in the lock-in program (see section 6.40.1);

6.40.6. Number of members identified with special healthcare needs by the PASRR Level II authority;

~~6.40.6.~~**6.40.7.** Number of members with assessments completed, and

~~6.40.7.~~**6.40.8.** Number of members with assessments resulting in a referral for Case Management.

6.41. Chronic Care Management Program (CCMP)

6.41.1. The MCO shall provide a Chronic Care Management Program (CCMP) for members diagnosed with the following chronic conditions:

6.41.1.1. Asthma;

6.41.1.2. Congestive heart failure;

6.41.1.3. Diabetes;

6.41.1.4. HIV;

6.41.1.5. Hepatitis C;

6.41.1.6. Obesity; and

6.41.1.7. Sickle Cell Anemia, particularly diagnosed members who are high utilizers of ED and inpatient services.

6.41.2. The program shall include information on work the plan has conducted in other states, if applicable; a measure of success; any state models planned for implementation in Louisiana; and a plan for partnering with national, state, or community foundations to support the work.

6.41.3. The MCO shall also include one of the following chronic conditions in the CCMP for its members: hypertension as a precursor to coronary artery disease and stroke; chronic obstructive pulmonary disease (COPD), low back pain and chronic pain. Additional chronic conditions may be added at the MCO's discretion. The MCO shall include additional discretionary chronic conditions in CCMP reports, as delineated for required chronic conditions in the CCMP, to DHH.

6.41.4. The MCO shall submit Chronic Care Management Program policies and procedures to DHH for approval within thirty (30) days of signing the Contract, annually and previous to any revisions. The MCO shall develop and implement policies and procedures that:

6.41.4.1. Include the definition of the target population;

6.41.4.2. Include member identification strategies, i.e., through encounter data;

6.41.4.3. Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;

6.41.4.4. Include guidelines for treatment plan development, as described in National Committee for Quality Assurance (NCQA) Disease Management program content, that provide the outline for all program activities and interventions;

6.41.4.5. Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;

6.41.4.6. Include methods for informing and educating members and providers;

6.41.4.7. Emphasize exacerbation and complication prevention utilizing evidence-based clinical practice guidelines and patient empowerment and activation strategies;

6.41.4.8. Address co-morbidities through a whole-person approach;

6.41.4.9. Identify members who require in-person case management services and a plan to meet this need;

6.41.4.10. Coordinate CCMP activities for members also identified in the Case Management Program; and

6.41.4.11. Include Program Evaluation requirements.

6.42. Predictive Modeling

6.42.1. The MCO shall use predictive modeling methodology to identify and stratify members eligible for the CCMP.

6.42.2. The MCO shall submit specifications of its Predictive Modeling methodology, including its risk scoring, stratum, and healthcare guidelines within thirty (30) days of signing the Contract and annually thereafter and prior to any changes. These specifications shall include but are not limited to:

6.42.2.1. A brief history of the tool's development and historical and current uses;

6.42.2.2. Medicaid data elements to be used for predictors and dependent measure(s);

6.42.2.3. Assessments of data reliability and model validity;

6.42.2.4. A description of the rules and strategy to achieve projected clinical outcomes and how clinical outcomes shall be measured; and

6.42.2.5. A description of how the model has been optimized on these type interventions and the constraints on intervention to the Medicaid program and population.

6.43. CCMP Reporting Requirements

6.43.1. The MCO shall submit Chronic Care Management reports quarterly to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.

6.43.2. The CCMP reports shall contain at a minimum:

6.43.2.1. Total number of members;

6.43.2.2. Number of members in each stratification level for each chronic condition; and

6.43.2.3. Number of members who were disenrolled from program and explanation as to why they were disenrolled.

6.43.3. The MCO shall submit the following report annually:

6.43.3.1. Chronic Care Management Program evaluation

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7.0 PROVIDER NETWORK REQUIREMENTS

7.1. General Provider Network Requirements

7.1.1. The MCO must maintain a network that ensures, at minimum, equal access to qualified providers as the rest of the insured population in the area. [42 CFR 438.210.(a)(2)]

7.1.2. All services covered under this contract shall be accessible to MCO members in comparable timeliness, amount, duration and scope as those available to other insured individuals in the same service area.

7.1.3. Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and time are fully outlined in this Section and in Appendix SS **– Provider Network – Appointment Availability Standards**. The MCO shall ensure that providers are available in network within the distance requirements set forth in this Section.

7.1.4. If the MCO is unable to provide the necessary services to a member within their network, the MCO must adequately and timely cover these services out of network. The MCO shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR §438.206.(b)(4) and (5)].

7.1.5. The MCO's network providers shall comply with all requirements set forth in this RFP.

7.1.6. The MCO shall require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and provide for cultural competency and linguistic needs, including the member's prevalent language(s) and sign language interpreters in accordance with 42 CFR §438.206(c)(2). MCOs must ensure that effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs are provided. Assurances shall be achieved by: ~~interpreters in accordance with 42 CFR §438.206(c)(2).~~

- Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required);
- Assessing the cultural competency of the providers on an ongoing basis, at least annually;
- Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.;
- Assessing provider satisfaction of the services provided by the MCO at least annually; and

- Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.

7.2. Appointment Availability Access Standards

7.2.1. The following appointment availability standards have been established as minimum requirements to ensure that members' needs are sufficiently met. DHH will monitor the MCO's compliance with these standards through regular reporting as shown in Appendix UU **– Provider Network – Geographic and Capacity Standards**. The MCO shall ensure that appointments with qualified providers are on a timely basis, as follows:

7.2.1.1. Emergent or emergency visits immediately upon presentation at the service delivery site. Emergent, crisis or emergency behavioral health~~Emergency~~ services must be available at all times and an appointment shall be arranged within one (1) hour of request;~~.~~

7.2.1.2. Urgent Care within twenty-four (24) hours.~~;~~ Provisions must be available for obtaining urgent care, including behavioral health care, 24 hours per day, 7 days per week. ~~-~~Urgent care may be provided directly by the PCP or directed by the MCO through other arrangements. An appointment shall be arranged within forty-eight (48) hours of request;

7.2.1.3. Non-urgent sick care within 72 hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;

7.2.1.4. Routine, non-urgent, or preventative care visits within 6 weeks. For behavioral healthcare, routine, non-urgent appointments shall be arranged within fourteen (14) days of referral;~~;~~

7.2.1.5. Specialty care consultation within 1 month of referral or as clinically indicated;

7.2.1.6. Lab and X-ray services (usual and customary) not to exceed three weeks for regular appointments and 48 hours for urgent care or as clinically indicated; and

7.2.1.7. Maternity Care

Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the MCO mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the MCO is pregnancy. The timeframes below apply for existing member or new members whose basis of eligibility is something other than pregnancy from the date the MCO or their subcontracted provider becomes aware of the pregnancy.

- Within their first trimester within 14 days;
- Within the second trimester within 7 days;
- Within their third trimester within 3 days;

- High risk pregnancies within 3 days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists;

7.2.1.8. Follow-up to ED visits in accordance with ED attending provider discharge instructions.

7.2.1.9. In office waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room.

7.2.1.10. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment.

7.2.1.11. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

7.2.1.12. Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.

7.3. Geographic Access Requirements

The MCO shall comply with the following maximum travel time and/or distance requirements, as determined by DHH approved mapping software (*e.g.* GeoAccess). Requests for exceptions as a result of prevailing community standards must be submitted in writing to DHH for approval. Such requests should include data on the local provider population available to the non-Medicaid population.

7.3.1. Primary Care Providers

7.3.1.1. Travel distance for members living in rural parishes shall not exceed 30 miles; and

7.3.1.2. Travel distance for members living in urban parishes shall not exceed 10 miles.

7.3.2. Acute Inpatient Hospitals

7.3.2.1. Travel distance for members living in rural parishes shall not exceed 30 miles; If no hospital is available within 30 miles of a member's residence, the MCO may request, in writing, an exception to this requirement.

7.3.2.2. Travel distance for members living in urban parishes shall not exceed 10 miles.

7.3.3. Specialists

7.3.3.1. Travel distance to each specialty type shall not exceed 60 miles for at least 75% of members; and

7.3.3.2. Travel distance shall not exceed 90 miles for all members.

7.3.3.3. Specialists included under this requirement are listed in Appendix TT – **Network Providers by Specialty Type.** DHH reserves the right to add

additional specialty types as needed to meet the medical needs of the member population.

7.3.3.4. Telemedicine may be used to facilitate access to specialists to augment MCO's network or to meet specific needs of a subset of the MCO's membership. If an MCO intends to utilize telemedicine to meet network adequacy requirements, the MCO's telemedicine utilization must be approved by DHH for this purpose.

7.3.4. Lab and Radiology Services

7.3.4.1. Travel distance shall not exceed 20 miles in urban parishes; and

7.3.4.2. Travel distance shall not exceed 30 miles for rural parishes.

7.3.5. Pharmacies

7.3.5.1. Travel distance shall not exceed 10 miles in urban parishes; and

7.3.5.2. Travel distance shall not exceed 30 miles in rural parishes.

7.3.6. Hemodialysis Centers

7.3.6.1. Travel distance shall not exceed 10 miles in urban areas; and

7.3.6.2. Travel distance shall not exceed 30 miles in rural areas.

7.3.7. Specialized Behavioral Health Providers

7.3.7.1. Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN CNS in mental health, or LCSW's) and to psychiatrists for members living in rural parishes shall not exceed 30 miles for 90% of such members.

7.3.7.2. Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles for 90% of such members.

7.3.7.3. Travel distance to Level III.3/5 Clinically Managed High Intensity Residential shall not exceed 30 miles for 90% of adult members, and shall not exceed 60 miles for adolescent members.

7.3.7.4. Travel distance to Level III.7 Medically Monitored Intensive Residential co-occurring treatment shall not exceed 60 miles for 90% of adult members.

7.3.7.5. Travel distance to Level III.7D Medically Monitored Residential Detoxification shall not exceed 60 miles for 90% of adult members.

7.3.7.6. Travel distance to Psychiatric Residential Treatment Facilities (PRTF) shall not exceed 200 miles for 90% of members.

7.3.7.7. Request for exceptions as a result of prevailing community standards for time and distance accessibility standards must be submitted in writing to DHH for approval.

7.3.7.8. There shall be no penalty if the member chooses to travel further than established access standards in order to access a preferred provider. The member shall be responsible for travel arrangements and costs.

7.4. Provider to Member Ratios

7.4.1. The MCO must demonstrate that their network has a sufficient number of providers and facilities to meet minimum ratio requirements and allow adequate access for members. Adequate ratios of providers to members can be found in Appendix UU.

7.5. Monitoring and Reporting on Provider Networks

7.5.1. Appointment Availability Monitoring

7.5.1.1. The MCO shall have written policies and procedures about educating its provider network about appointment time requirements. The MCO must include their appointment standards in the Provider Manual and shall disseminate appointment standards and procedures to its members and include this information on their website. The MCO is encouraged to include the standards in the provider subcontracts.

7.5.1.2. The MCO is responsible for monitoring and assurance of provider compliance with appointment availability standards and provision of appropriate after-hour coverage.

7.5.2. Geographic Availability Monitoring

7.5.2.1. The MCO shall submit quarterly GeoAccess reports documenting the geographic availability of network providers including PCPs, hospitals, pharmacies, and each specialty type listed in Appendix UU. The attestation included with this report shall provide narrative identifying any gaps in coverage and the corrective measures that will address them.

7.5.2.2. The data in the quarterly GeoAccess reports shall be consistent with provider registry data submitted to DHH by the plans as required in the MCO Systems Companion Guide.

7.5.2.3. The MCO report on accessibility shall include assessment of coverage including distance, population density, and provider availability variables. All gaps in coverage must be identified and addressed in the Network Development Plan.

7.5.3. Provider to Member Ratios

7.5.3.1. Quarterly GeoAccess reports shall include analysis of provider-to-member ratios in each geographical area as outlined in this Section and Appendix UU.

7.5.3.2. Member linkages to Primary Care providers shall be submitted to DHH weekly as described in the MCO Systems Companion Guide.

7.6. Provider Enrollment

7.6.1. Provider Participation

7.6.1.1. The MCO must offer a contract to the following providers:

- Louisiana Office of Public Health (OPH);
- All OPH-certified School Based Health Clinics (SBHCs);
- All small rural hospitals meeting the definition in the Rural Hospital Preservation Act of 1997;
- Federally Qualified Health Centers (FQHCs);
- Rural Health Clinics (RHCs) (free-standing and hospital based);
- The MCO shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act services; and)
- All providers approved by the DHH PSH program to provide tenancy and pre-tenancy supports for the Louisiana Permanent Supportive Housing program.

7.6.1.1.1. The MCO must offer a contract to the following behavioral health provider types for specialized behavioral health services for the first twenty-two (22) months after integration. The time period for extending this requirement shall be decided by DHH:

- Rural Health Clinics (RHCs);
- Local Governing Entities;
- Federally Qualified health Centers;
- Methadone Clinics pending CMS approval;
- Providers of addiction services for youth and adults at all levels of care (i.e., ASAM Levels I, II.1, II.D, III.1, III.2D, III.3, III.5, III.7, III.7D, IV.D);
- Providers of Evidenced Based Practices (EBPs), i.e. Assertive Community Treatment (ACT), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Homebuilders®;
- Providers trained to implement specialized behavioral health services for the at-risk youth population age zero (0) – age six (6) [e.g. Parent Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP) and Parent Management Training (PMT)];
- All current Psychiatric Residential Treatment Facilities (PRTFs) and Therapeutic Group Homes (TGHs);-
- Mental Health Rehabilitation (MHR) Agencies;

- Current LMHPs (Psychologists, LCSW, LPC, LMFT, LAC, APRNs).

7.6.1.2. The MCO shall make a good faith effort to execute a contract with significant traditional providers (STPs). In the event an agreement cannot be reached and a STP does not participate in the MCO, the MCO shall maintain documentation detailing efforts that were made.

7.6.1.3. If a current Medicaid provider requests participation in an MCO, the MCO shall make a good faith effort to execute a contract. In the event an agreement cannot be reached and the provider does not participate in the MCO, the MCO has met this requirement; the MCO shall maintain documentation detailing efforts made.

7.6.1.4. The provisions above (7.65.1.2 and 7.65.1.3) do not prohibit the MCO from limiting provider participation to the extent necessary to meet the needs of the MCO's members. These provisions also do not interfere with measures established by the MCO to control costs and quality consistent with its responsibilities under this contract nor does it preclude the MCO from using reimbursement amounts that are the greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR §438.12(b)(1)].

7.6.1.5. If the MCO declines requests of individuals or groups of providers to be included in the MCO network, the MCO must give the requested providers written notice of the reason for its decision within fourteen (14) calendar days of its decision [42 CFR §438.12(a)(1)].

7.6.1.6. The MCO shall work with DHH and other MCOs to convene local/regional forums to explore care coordination and care integration and build partnerships with providers.

7.6.2. Exclusion from Participation

7.6.2.1. The MCO shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act [42 CFR §438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/ , and Health Integrity and Protection Data Bank at http://www.npdb-hipdb.hrsa.gov/index.jsp.

7.6.3. Other Enrollment and Disenrollment Requirements

7.6.3.1. The MCO shall not discriminate with respect to participation in the MCO program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR §438.12(a)(1) and (2)]. In addition, the MCO shall not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR §438.214(c)].

7.6.3.2. All providers shall be in compliance with American with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities.

7.6.3.3. If the MCO terminates a provider's contract for cause, the MCO shall provide immediate written notice to the provider. The MCO shall notify DHH of the termination as soon as possible, but no later than seven (7) calendar days, of written notification of cancelation to the provider.

7.6.3.4. The MCO shall make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt of issuance of the termination notice, to each MCO member who received his or her primary care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(5).

7.7. Mainstreaming

7.7.1. DHH considers mainstreaming of MCO members into the broader health delivery system to be important. The MCO therefore must ensure that all MCO providers accept members for treatment and that MCO providers do not intentionally segregate members in any way from other persons receiving services.

7.7.2. To ensure mainstreaming of members, the MCO shall take affirmative action so that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

7.7.2.1. Denying or not providing to a member any covered service or availability of a facility.

7.7.2.2. Providing to a member any covered service which is different, or is provided in a different manner, or at a different time from that provided to other members, other public or private patients, or the public at large.

7.7.2.3. Discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, separate physical locations, or preference to private pay or Medicaid fee-for-service patients.

7.7.3. When the MCO becomes aware of a specialized behavioral health provider's failure to comply with mainstreaming, the MCO shall develop a written plan for coming into compliance with the Contract requirement for mainstreaming with the behavioral health provider within thirty (30) calendar days and notify DHH in writing.

7.7.4. The MCO shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.

7.8. Primary Care

The PCP shall serve as the member's initial and most important point of interaction with the MCO's provider network. A PCP in the MCO must be a provider who provides or arranges for the delivery of medical services, including case management, to assure that all services, which are found to be medically necessary, are made available in a timely manner as outlined in this Section.

7.8.1. Assignment of Primary Care Providers

7.8.1.1. As part of the financial Medicaid application process, applicants may be given the option to indicate their preferred choice of MCO .

7.8.1.2. If the choice of MCO is not indicated on the new eligible file transmitted by DHH to the Enrollment Broker, the Enrollment Broker shall contact the eligible individual to request their choice of MCO and if available the PCP of choice.

7.8.1.3. The Enrollment Broker shall encourage the continuation of any existing satisfactory provider/patient relationship with their current PCP who is in an MCO.

7.8.1.4. The name of PCP requested by a new enrollee will be included in the Member File from the Enrollment Broker to the MCO.

7.8.1.5. The MCO shall confirm the PCP selection information in a written notice to the member.

7.8.1.6. If no PCP is selected on the Member File received from the Enrollment Broker, the MCO shall contact the member, as part of the welcome call, within ten (10) business days of receiving the Member File from the Enrollment Broker to assist the member in making a selection of a PCP or auto assign a PCP;

7.8.1.7. Inform the member that each family member has the right to choose his/her own PCP. The MCO may explain the advantages of selecting the same primary care provider for all family members, as appropriate.

7.8.1.8. Members, for whom an MCO is the primary payor, who do not proactively choose a PCP will be auto-assigned to a PCP by the MCO. Members, for whom an MCO is a secondary payor, will not be assigned to a PCP by the MCO, unless the members request that the MCO do so.

7.8.1.9. The MCO shall be responsible for providing to the Enrollment Broker, information on the number of Medicaid member linkages and remaining capacity of each individual PCP of additional Medicaid member linkages on a quarterly basis.

7.8.1.10. If the member does not select a PCP and is auto assigned to a PCP by the MCO, the MCO shall allow the member to change PCP, at least once, during the first ninety (90) days from assignment to the PCP without cause.

7.8.1.11. Effective the ninety-first (91st) day, the member may be locked into the assignment to the selected PCP for a period of up to twelve months (12)

months beginning from the original date the member was assigned to the MCO.

7.8.1.12. If a member requests to change his or her PCP with cause, at any time during the enrollment period, the MCO must agree to grant the request.

7.8.1.13. The MCO shall have written policies and procedures for allowing members to select a new PCP, including auto-assignment, and provide information on options for selecting a new PCP when it has been determined that a PCP is non-compliant with provider standards (i.e. quality of care) and is terminated from the MCO, or when a PCP change is ordered as part of the resolution to a grievance proceeding. The MCO shall allow members to select another PCP within ten (10) business days of the postmark date of the termination of PCP notice to members and provide information on options for selecting a new PCP.

7.8.1.14. The MCO shall have policies for accessing emergency/urgent care during this transition period. These policies and procedures shall be submitted within thirty (30) days from the date the MCO signs the Contract with DHH.

7.8.1.15. The MCO shall notify the Fiscal Intermediary by close of business the next business day of a PCP's termination.

7.8.1.16. The MCO shall have written policies and procedures for handling the assignment of its members to a PCP. The MCO is responsible for linking to a PCP all assigned MCO members for whom the MCO is the primary payor.

7.8.1.17. PCP Auto-Assignments

7.8.1.17.1. The MCO is responsible for developing a PCP automatic assignment methodology in collaboration with DHH to assign to a PCP an enrollee for whom the MCO is the primary payor when the enrollee:

7.8.1.17.2. Does not make a PCP selection after a voluntary selection of an MCO; or

7.8.1.17.3. Selects a PCP within the MCO that has reached their maximum physician/patient ratio; or

7.8.1.17.4. Selects a PCP within the MCO that has restrictions/limitations (*e.g.* pediatric only practice).

7.8.1.17.5. Does not make a selection of a PCP for a newborn within fourteen (14) calendar days of birth. The effective date of a PCP selection or assignment of a newborn will be no later than the first month of enrollment subsequent to the birth of the child.

7.8.1.17.6. Assignment shall be made to a PCP with whom, based on fee-for-service claims history or prior linkage, the member has a historical provider relationship. If there is no historical PCP relationship, the member shall be auto-assigned to a provider who is the assigned PCP for an immediate family member enrolled in the MCO plan. If other immediate family members do not have an assigned PCP, auto-

assignment shall be made to a provider with who a family member has a historical provider relationship.

7.8.1.17.7. If there is no member or immediate family historical usage, members shall be auto-assigned to a PCP using an algorithm developed by the proposer, based on the age and sex of the member and geographic proximity.

7.8.1.17.8. The final MCO PCP automatic assignment methodology must be provided thirty (30) days from the date the MCO signs the contract with DHH Approval must be obtained from the Department prior to implementation. This methodology must be made available via the MCO's website, Provider Handbook, and Member Handbook.

7.8.2. Primary Care Provider Responsibilities

The MCO must ensure that network Primary Care Providers fulfill their responsibilities including but not limited to the following:

7.8.2.1. Managing and coordinating the medical and behavioral health care needs of members to assure that all medically necessary services are made available in a timely manner;

7.8.2.2. Referring patients to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available;

7.8.2.3. Communicating with all other levels of medical care to coordinate, and follow up the care of individual patients

7.8.2.4. Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services available through fee-for-service Medicaid;

7.8.2.5. Maintaining a medical record of all services rendered by the PCP and a record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow up and/or coordination of care;

7.8.2.6. Development of plan of care to address risks and medical needs and other responsibilities as defined in Section 6.33.

7.8.2.7. Ensuring that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information and all state statutes.

7.8.2.8. Providing after-hours availability to patients who need medical advice. At minimum, PCP office must have a return call system staffed and monitored in order to assure that the member is connected to a designated medical practitioner within 30 minutes of the call.

7.8.2.9. Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital.

7.8.2.10. Working with MCO case managers to develop plans of care for members receiving case management services.

7.8.2.11. Participating in the MCO's case management team, as applicable and medically necessary.

7.8.2.12. Conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, to determine whether the member needs behavioral health services.

7.8.3. Specialty Providers

7.8.3.1. The MCO shall assure access to specialty providers, as appropriate, for all members. The MCO shall assure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.

7.8.3.2. The MCO provider network shall include participating specialists with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (*e.g.* a pediatric cardiologist).

7.8.3.3. The MCO shall ensure access to appropriate service settings for members needing medically high risk perinatal care, including both prenatal and neonatal care,

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

- The MCO has signed a contract with providers of the specialty types listed in Appendix TT who accept new members and are available on at least a referral basis; and
- The MCO is in compliance with access and availability requirements.

7.8.3.5. The MCO shall assure, at a minimum, the availability of the specialists listed in Appendix TT with the ratio, distance, and appointment time requirements set in this Section and in Appendices SS and UU**.**

7.8.3.6. The MCO will be required to provide a higher ratio of specialists per member population and/or additional specialist types/member ratios may be established, if it is determined by DHH the MCO does not meet the access standards specified in the Contract.

7.8.3.7. In accordance with 42 CFR §438.208(c)(4), for enrollees determined to need a course of treatment or regular monitoring, the MCO must have a

mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.

7.8.4. Hospitals

7.8.4.1. Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this RFP.

7.8.4.2. The MCO shall include, at a minimum, access to the following:

7.8.4.2.1. One (1) hospital that provides emergency room services, inpatient, and outpatient care in each parish in the state, provided the parish has such a hospital.

7.8.4.2.2. MCO must establish access to the following within their network of hospitals:

- Level III Obstetrical services;
- Level III Neonatal Intensive Care (NICU) services;
- Pediatric services;
- Trauma services;
- Burn services; and
- A Children's Hospital that meets the CMS definition in 42 CFR Parts 412 and 413

7.8.4.3. The MCO may contract with out-of-state hospitals in the trade area.

7.8.4.4. If there are no hospitals within the parish that meet these requirements in section 7.8.4.2.1, or a contract cannot be negotiated, the MCO may contract with out-of-state hospitals to comply with these requirements.

7.8.5. Tertiary Care

Tertiary care is defined as health services provided by highly-specialized providers, such as medical sub-specialists; these services frequently require complex technological and support facilities. The MCO shall provide tertiary care services including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day. If the MCO does not have a full range of tertiary care services, the MCO shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers.

7.8.6. Direct Access to Women's Health Care

The MCO shall provide direct access to a health specialist(s) in-network for core benefits and services necessary to provide women's routine and preventive health care services. This access shall be in addition to the member's PCP if that provider is not a women's health specialist.

7.8.6.1. The MCO shall notify and give each member, including adolescents, the opportunity to use their own PCP or utilize any family planning service

provider for family planning services without requiring a referral or authorization. Family planning services shall be available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments and traditional contraceptive devices. The MCO family planning services shall also include preconception and interconception care services for members to optimize member health entering pregnancy. The MCO shall agree to make available all family planning services to MCO members as specified in this RFP.

7.8.6.2. MCO members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions as specified in 42 CFR §431.51(b)(2). The out-of-network Medicaid enrolled family planning services provider shall bill the MCO and be reimbursed no less than the Medicaid rate in effect on the date of service. MCO members should be encouraged by the MCO to receive family planning services through the MCO's network of providers to ensure continuity and coordination of the member's total care. No additional reimbursements shall be made to the MCO for MCO members who elect to receive family planning services outside the MCO's provider network.

7.8.6.3. The MCO may require family planning providers to submit claims or reports in specified formats before reimbursing services.

7.8.6.4. The MCO shall maintain the confidentiality of family planning information and records for each individual member including those of minor patients.

7.8.7. Prenatal Care Services

7.8.7.1. The MCO shall assist all pregnant members in choosing a pediatrician, or other appropriate PCP, for the care of their newborn babies before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the MCO shall provide the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one. The MCO shall cover all newborn care rendered within the first month of life regardless if provided by the designated PCP or another network provider. The MCO shall compensate, at a minimum, ninety percent (90%) of the Medicaid fee-for-service rate in effect for each service coded as a primary care service rendered to a newborn member within thirty days of the member's birth regardless of whether the provider rendering the services is contracted with the MCO, but subject to the same requirements as a contracted provider.

7.8.8. Other Service Providers

The MCO shall ensure the availability of medical service providers including, but not limited to, ambulance services, durable medical equipment, orthotics, prosthetics and certain supplies, and radiology, and laboratories. All services must be provided in accordance with applicable state and federal laws and regulations.

7.8.9. Non-Emergency Medical Transportation

7.8.9.1. MCO shall have sufficient NEMT providers, including wheelchair lift equipped vans, to transport members to medically necessary services when notified 48 hours in advance, and MCOs must be able to arrive and provide services with sufficient time to ensure the member arrives at their appointment at least 15 minutes but no more than 1 hour early.

7.8.9.2. For medically necessary non-emergent transportation requested by the member or someone on behalf of the member, the MCO shall require its transportation contractor to schedule the transportation so that the member arrives on time but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment.

7.8.9.3. If a member requests an MCO provider who is located beyond access standards, and the MCO has an appropriate provider within the MCO who accepts new patients, it shall not be considered a violation of the access requirements for the MCO to grant the member's request. However, in such cases the MCO shall not be responsible for providing transportation for the member to access care from this selected provider, and the MCO shall notify the member in writing as to whether or not the MCO will provide transportation to seek care from the requested provider.

7.8.10. FQHC/RHC Clinic Services

7.8.10.1. The MCO must offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) in the state.

7.8.10.2. See Section 9 of this RFP for FQHC/RHC reimbursement requirements

7.8.11. School-Based Health Clinics (SBHCs)

7.8.11.1. SBHC (certified by the DHH Office of Public Health) services are those Medicaid services provided within school settings to Medicaid eligible children under the age of 21.

7.8.11.2. The MCO must offer a contract to each SBHC. The MCO may stipulate that the SBHC follow all of the MCO's required policies and procedures.

7.8.12. Laboratory

7.8.12.1. All laboratory testing sites providing services under this Contract must have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.

7.8.13. Local Parish Health Clinics

7.8.13.1. The MCO must offer a contract to the Louisiana Office of Public Health (OPH) for the provision of personal health services offered within the parish health units (*e.g.* immunizations, STD, family planning).

7.8.13.2. The MCO shall coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for addressing public health issues shall be negotiated with OPH and BHSF (Medicaid) and reflect

Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF (Medicaid), and the MCO.

7.8.14. Specialized Behavioral Health Providers

7.8.14.1. The MCO shall work with the existing network of behavioral health providers to ensure behavioral health services are offered to address the needs of youth with serious emotional disorders, adults with Serious Mental Illness (SMI), members with substance use disorders, members with co-occurring including mental health and substance use disorders and other developmental disorders. This shall include coordination with the Local Governing Entities (LGEs) for the provision of Medicaid services.

7.8.14.2. The MCO shall ensure its provider network offers an appropriate range of preventive and specialized behavioral health services as reflected in the DHH Behavioral Health Provider Manual Service Definitions Manual that is adequate for the anticipated number of members for the service area, including compliance with the waivers and Medicaid State Plan requirements.

7.8.14.3. The MCO shall design its provider network to maximize the availability of community-based behavioral healthcare that reduces utilization of emergency services when lower cost community-based services are available and eliminates preventable hospital admissions.

7.8.14.4. The MCO shall design its provider network to increase the emerging use of peers as providers. This includes peers providing required peer services (i.e., required peer services such as Youth Support Training and Parent Support Training), in lieu of peer services, and peers certified to serve as qualified providers of other state plan/waiver services (including, but not limited to, PSR or CPST).

7.8.14.5. The MCO shall ensure that within the provider network, members enrolled in Home and Community Based waiver services have a choice of behavioral health providers, which offer the appropriate level of care and may change providers in accordance with Medicaid home and community based waiver requirements pertaining to Freedom of Choice.

7.8.14.6. The MCO shall ensure the provider network has a sufficient number of prescribers and other qualified behavioral health service providers to deliver services during evenings and weekends for members or their families/caregivers who are unavailable for appointments during traditional business hours.

7.8.14.7. The MCO shall have a fully operational network of behavioral health crisis response providers offering a complete array of crisis services, available twenty-four (24) hours per day, seven (7) days per week. The community-based crisis response system may include, but is not limited to, an on-call, 24-hour crisis hotline, warm line, crisis counseling, behavioral health management and intervention, mobile crisis teams, and crisis stabilization in an alternative settings.

If shortages in provider network sufficiency are identified by DHH, the MCO shall conduct outreach efforts approved by DHH, and take necessary actions to assure member access to medically necessary behavioral health services. The MCO shall execute an ad hoc or single case agreement when a clinical need or a specialized behavioral health service is identified for a member and no network provider is available to meet that particular need. In such cases, all transportation necessary to receive necessary services will be provided and reimbursed through the MCO, including meals and lodging as appropriate.

7.8.14.8. The MCO must ensure that all placements are at the most appropriate and medically necessary level to treat the specialty needs of the member.

7.8.14.9. The MCO shall require behavioral health providers to screen for basic medical issues, such as utilizing the healthy living questionnaire 2011 or the PBHCI medical screening short form.

7.8.14.10. The MCO shall monitor and support development of local provider capacity for the purpose of identifying and filling gaps in service availability.

7.9. Network Provider Development Management Plan

7.9.1. The MCO shall develop and maintain a provider Network Development and Management Plan which ensures that the provision of core benefits and services will occur [42 CFR §438.207(b)]. The Network Development and Management Plan shall be submitted to DHH as part of the proposal, as well as when significant changes occur and at least annually thereafter. The Network Development and Management Plan shall include the MCO's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services included in the Contract. When designing the network of providers, the MCO shall consider the following (42 CFR §438.206):

7.9.1.1. Anticipated maximum number of Medicaid members;

7.9.1.2. Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the MCO;

7.9.1.3. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core benefits and services;

7.9.1.4. The numbers of MCO providers who are not accepting new MCO members; and

7.9.1.5. The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid enrollees with disabilities.

7.9.2. The Network Provider Development and Management Plan shall demonstrate access to Services and Benefits as defined in this RFP, access standards in 42 CFR §438.206 and shall include:

7.9.2.1. Assurance of Adequate Capacity and Services

7.9.2.2. Access to Primary Care Providers

7.9.2.3. Access to Specialists

7.9.2.4. Access to Hospitals

7.9.2.5. Access to Behavioral Health Services

~~**7.9.2.5.**~~**7.9.2.6.** Timely Access

~~**7.9.2.6.**~~**7.9.2.7.** Service Area

~~**7.9.2.7.**~~**7.9.2.8.** Other Access Requirements

- Direct Access to Women's Health
- Special Conditions for Prenatal Providers
- Second Opinion
- Out-of-Network Providers

7.9.3. The Network Provider Development and Management Plan shall identify gaps in the MCO's provider network and describe the process by which the MCO shall assure all covered services are delivered to MCO members. Planned interventions to be taken to resolve such gaps shall also be included.

7.9.4. The MCO shall provide GEO mapping and coding of all network providers for each provider type by the deadline specified in the Schedule of Events, to geographically demonstrate network capacity. The MCO shall provide updated GEO coding to DHH quarterly, or upon material change (as defined in the Glossary) or upon request.

7.9.5. The MCO shall develop and implement Network Development and Management policies and policies detailing how the MCO will [42 CFR §438.214(a)]:

7.9.5.1. Communicate and negotiate with the network regarding contractual and/or program changes and requirements;

7.9.5.2. Monitor network compliance with policies and rules of DHH and the MCO, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;

7.9.5.3. Evaluate the quality of services delivered by the network;

7.9.5.4. Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;

7.9.5.5. Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English; and

7.9.5.6. Process expedited and temporary credentials. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling;

7.9.5.7. Provide training for its providers and maintain records of such training;

7.9.5.8. Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;

7.9.5.9. Ensure that provider complaints are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 business days of receipt (this includes referrals from DHH). If not resolved in 30 days the MCO must document why the issue goes unresolved; however, the issue must be resolved within 90 days.

7.9.6. An evaluation of the initial Network Provider Development and Management Plan, including evaluation of the success of proposed interventions and any needed revisions, shall be submitted to DHH at the end of the first year of operations and annually thereafter.

7.9.7. MCO Network Development and Management policies shall be subject to approval by DHH, Medicaid Managed Care Section and shall be monitored through operational audits.

7.9.8. Specialized Behavioral Health Network Development and Management Plan

An initial Network Development and Management Plan focusing on specialized behavioral health providers shall be submitted to DHH by November 1, 2015. Thereafter, the Specialized Behavioral Health network shall be included in a distinct section of the overall MCO Network Development and Management Plan which shall be updated at least annually or more often as needed to reflect material changes in network status.

7.9.8.1. The plan shall contain separate sections for each specialized behavioral health provider type for all covered specialized behavioral health services for both children and adults, and satisfy all service delivery requirements described in this contract.

7.9.8.2. The MCO's Network Development and Management Plan shall include the following requirements for specialized behavioral health providers:

- The methodology the MCO will use for the evaluation of specialized behavioral health providers' ability to perform activities associated with this contract;
- The numbers and types (in terms of training, experience, and specialization) of specialized behavioral health providers required to furnish the contracted specialized behavioral health services, including providers of specialized services (e.g., DD population, sexual offending behaviors, and early childhood development);

- GEO mapping and coding of all specialized behavioral health network providers for each specialized behavioral health provider type to geographically demonstrate network capacity. The MCO shall provide updated GEO mapping and coding to DHH quarterly by contract year, upon material change of the network, or upon request;

- An annual needs assessment to identify unmet service needs in the specialized behavioral health service delivery system. The needs assessment shall analyze and include:

  - Volume of single case agreements and out-of-network, out-of-state and telemedicine referrals for specialized behavioral health services;

  - Specialized behavioral health service needs of members; and

  - Growth trends in eligibility and enrollment, including:

    - Current and anticipated numbers of Title XIX and Title XXI eligibles; and

    - Current and desired specialized behavioral health service utilization trends, including prevalent diagnoses, age, gender, and race/ethnicity characteristics of the enrolled population by region; best practice approaches; and network and contracting models consistent with DHH goals and principles.

- Accessibility of services, including:

  - The number of current qualified specialized behavioral health service providers by individual specialized behavioral health service in the network who are not accepting new Medicaid referrals and a plan for updating on a regular, reoccurring basis as close to real time as possible;

  - The geographic location of specialized behavioral health providers and members considering distance, travel time, and available means of transportation;

  - Availability of specialized behavioral health services and appointments with physical access for persons with disabilities; and

  - Any service access standards detailed in a SPA or waiver.

7.9.8.3. The MCO shall submit to DHH as part of its annual Network Development and Management Plan, and upon request of DHH, specialized behavioral health provider profiling data, which shall include:

- Member eligibility/enrollment data;

- Specialized behavioral health service utilization data;

- The number of single case agreements by specialized behavioral health service type;

- Specialized behavioral health treatment and functional outcome data;

- The number of members diagnosed with developmental/cognitive disabilities;

- The number of prescribers required to meet specialized behavioral health members' medication needs;
- The efforts given to recruit specialized behavioral health providers and specialty providers to address any unmet need;
- Provider grievance, appeal and request for arbitration data; and
- ~~Member grievance, appeal and request for hearings data; and~~Issues, concerns and requests identified by other state agency personnel, local agencies and community stakeholders.

7.9.8.4. ~~Issues, concerns and requests identified by other state agency personnel, local agencies and community stakeholders.~~ For adults, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that:

- Includes qualified specialized behavioral health service providers and community resources designed and contracted to deliver specialized behavioral healthcare that is strength-based, community-based, and culturally competent;
- Includes specific specialized behavioral health services for adults eligible for services as defined in this contract;
- Is of sufficient size and scope to offer members a choice of providers for all covered specialized behavioral health services;
- Makes uniformly available over time recognized EBPs, best practices and culturally competent services that promote resiliency through nationally recognized integrated service models; and

  Provides adequate, proactive development and monitoring of community-based options that limit reliance on hospital based services.

7.9.8.5. For children, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that includes the above elements for adults as well as:

- Includes specific specialized behavioral health services for children;
- Targets the development of family and community-based services for children/youth in out-of-home placements;
- Increases access to family and community-based services, optimizing the use of natural and informal supports and reduces reliance on out-of-home placements; and
- Provides adequate, proactive development and monitoring of in-state regional out-of-home options to serve the needs of youth in the state.

7.9.8.6. The Network Development and Management Plan shall state that the MCO's provider network meets requirements with regard to cultural competence and linguistics as follows:

- Cultural competence and linguistic needs, including the member's prevalent language(s) and sign language in accordance with 42 CFR §438.206;

- Provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. This shall be achieved by:

  - Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required);

  - Assessing the cultural competence of the providers on an ongoing basis, at least annually;

  - Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.;

  - Assessing provider satisfaction of the services provided by the MCO at least annually; and

  - Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.

7.9.8.7. The Network Development and Management Plan shall be inclusive of an evaluation of the initial Network Development and Management Plan in each subsequent year, which shall include evaluation of the success of proposed interventions, barriers to implementation, and any needed revisions pertaining to the delivery of specialized behavioral healthcare.

7.10. Patient-Centered Medical Home (PCMH)

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

7.10.2. The MCO shall promote and facilitate the capacity of primary care practices to function as patient-centered medical homes by using systematic, patient-centered coordinated care management processes and Health Information Technology to deliver improve quality of care, health outcomes and patient compliance and satisfaction.

7.10.3. PCMH transformation efforts, may include but are not limited to the attainment of National Committee on Quality Assurance (NCQA) Physician Practice Connections®-Patient-Centered Medical Home (PPC®-PCMH) recognition or

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Primary Care Home (PCH) accreditation.

7.10.4. The MCO shall provide a PCMH Implementation Plan within ninety (90) days of the "go live" date of this contract that identifies the methodology for promoting practice transformation to providing PCMHs for its members. The Plan shall include but is not limited to the following:

7.10.4.1. Any payment methodology for payment to primary care practices for the specific purpose of supporting necessary costs to transform and sustain a medical home practice:

7.10.4.2. Provision of technical support, to assist in their transformation ;

7.10.4.3. Facilitation of specialty provider network access and coordination to support the PCMH;

7.10.4.4. Efforts to increase and support the provision of appropriate basic behavioral services in the primary care setting, as well as, the coordination of services with specialty behavioral health providers and other community support services;

7.10.4.5. Facilitation of data interchange between PCMH practices, specialists, labs, pharmacies, and other providers.

7.10.4.6. Methodology for evaluating the level of practice participation, level of practice transformation and any capacity and/or health outcomes achieved, The findings from all evaluations shall be included in the annual update of the PCMH Implementation Plan.

7.11. Material Change to Provider Network

7.11.1. The MCO shall provide written notice to DHH, no later than seven (7) business days of any network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. A material change is defined as one which affects, or can reasonably be foreseen to affect, the MCO's ability to meet the performance and network standards as described in the Contract, including but not limited to the following:

7.11.1.1. Any change that would cause more than five percent (5%) of members within the service area to change the location where services are received or rendered.

7.11.1.2. A decrease in the total of individual PCPs by more than five percent (5%);

7.11.1.3. A loss of any participating specialist which may impair or deny the members' adequate access to providers;

7.11.1.4. A loss of a hospital in an area where another MCO hospital of equal service ability is not available as required by access standards specified in this RFP; or

7.11.1.5. Other adverse changes to the composition of the MCO which impair or deny the members' adequate access to providers.

7.11.2. The MCO shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in expanded services, payments, or eligibility of a new population.

7.11.3. When the MCO has advance knowledge that a material change will occur, the MCO must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.

7.11.4. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them.

7.11.5. If DHH does not respond within thirty (30) days the request and the notice are deemed approved. A material change in the MCO's provider network requires thirty (30) days advance written notice to affected members For emergency situations, DHH will expedite the approval process.

7.11.6. The MCO shall notify the DHH/BHSF/Medicaid Managed Care Section within one (1) business day of the MCO becoming aware of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR §438.207(c)]. The notification shall include:

7.11.6.1. Information about how the provider network change will affect the delivery of covered services, and

7.11.6.2. The MCO's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.

7.11.7. MCO's shall give hospitals and provider groups ninety (90) days' notice prior to a contract termination without cause. Contracts between the MCO and single practitioners are exempt from this requirement.

7.11.8. As it pertains to a material change in the network for behavioral health providers, the MCO shall also:

7.11.8.1. Provide written notice to DHH, no later than seven (7) business days of any behavioral health network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. Material changes in addition to those noted in Section 7.11 include:

- A decrease in a behavioral health provider type by more than five percent (5%);
- A loss of any participating behavioral health specialist which may impair or deny the members' adequate access to providers; or

- A loss of a hospital or residential treatment in an area where another provider of equal service ability is not available as required by access standards approved by DHH.

7.11.8.2. The MCO shall provide or arrange for medically necessary covered services should the network become temporarily insufficient within a service area.

7.11.8.3. When the MCO has advance knowledge that a material change will occur to its network of behavioral health providers, the MCO must submit a written request for approval of the material change in their provider network to DHH, including a copy of draft notification to affected members, sixty (60) calendar days prior to the expected implementation of the change.

7.11.8.3.1. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them, including:

- Detailed information identifying the affected provider;
- Demographic information and number of members currently served and impacted by the event or material change, including the number of Medicaid members affected by program category;
- Location and identification of nearest providers offering similar services; and
- A plan for clinical team meetings with the member, his/her family/caregiver, and other persons requested by the member and/or legal guardian to discuss available options and revise the service plan to address any changes in services or service providers.

7.11.8.4. If a provider loss results in a material gap or behavioral health network deficiency, the MCO shall submit to DHH a written plan with time frames and action steps for correcting the gap or deficiency within thirty (30) calendar days that includes the transitioning of members to appropriate alternative behavioral health service providers in accordance with the network notification requirements.

7.11.8.5. The MCO shall track all members transitioned due to a subcontract's suspension, limitation, termination, or material change to ensure behavioral health service continuity and provide member information as requested by DHH (e.g., name, Title XIX or Title XXI status, date of birth, services member is receiving or will be receiving, name of new provider, date of first appointment, and activities to re-engage persons who miss their first appointment with the new provider).

7.12. Coordination with Other Service Providers

The MCO shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; Aging and Disability Councils, Areas on Aging, and school systems. Such cooperation may include performing annual

physical examinations for schools and the sharing of information (with the consent of the enrollee).

7.13. Provider Subcontract Requirements

7.13.1. In order to ensure that members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, the MCO shall not have a contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another MCO or in which the MCO represents or agrees that it will not contract with another provider. The MCO shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.

7.13.2. The MCO shall have written policies and procedures for selection and retention of providers in accordance with 42 CFR §438.214.

7.13.2.1. Within 30 days of the MCO signing the contract, it shall provide DHH with written provider credentialing and re-credentialling policies that are compliant with NCQA Health Plan Accreditation standards and all applicable state laws

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

7.13.3. As required by 42 CFR §438.6(1), §438.230(a) and § 438.230(b)(1),(2),(3) the MCO shall be responsible to oversee all subcontractors' performance and shall be held accountable for any function and responsibility that it delegates to any subcontractor, including, but not limited to:

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

7.13.3.2. DHH shall have the right to review and approve or disapprove any and all provider subcontracts entered into for the provision of any services under this RFP.

7.13.3.3. The MCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated;

7.13.3.4. The MCO must have a written agreement between the MCO and the subcontractor that specifies the activities and reporting responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;

7.13.3.5. The MCO shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards;

7.13.3.6. The MCO shall identify deficiencies or areas for improvement, and take corrective action; and

7.13.3.7. The MCO shall specifically deny payments to subcontractors for Provider Preventable Conditions.

7.13.4. The MCO shall submit all major subcontracts, excluding provider subcontracts, for the provision of any services under this RFP to DHH for prior review and approval. DHH shall have the right to review and approve or disapprove any and all provider subcontracts entered into for the provision of any services under this RFP.

7.13.5. Notification of amendments or changes to any provider subcontract which, in accordance with Section 7.6 of this RFP, materially affects this Contract, shall be provided to DHH prior to the execution of the amendment in accordance with Section 23.1 of this RFP.

7.13.6. The MCO shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §1128 of the Social Security Act (42 U.S.C. §1320a-7) or §1156 of the Social Security Act (42 U.S.C. §1320c-5) or who are otherwise barred from participation in the Medicaid and/or Medicare program. The MCO shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

7.13.7. The MCO shall provide written notification to DHH of its intent to terminate any provider subcontract that may materially impact the MCO's provider network and/or operations, as soon as possible, but no later than seven (7) calendar days prior to the effective date of termination. In the event of termination of a provider subcontract for cause, the MCO shall provide immediate written notice to the provider.

7.13.8. If termination is related to network access, the MCO shall include in the notification to DHH their plans to notify MCO members of such change and strategy to ensure timely access to MCO members through out-of-network providers. If termination is related to the MCO's operations, the notification shall include the MCO's plan for how it will ensure that there will be no stoppage or interruption of services to member or providers.

7.13.9. The MCO shall make a good faith effort to give written notice of termination of a subcontract provider, within fifteen (15) days after receipt of issuance of the termination notice, to each MCO member who received his or her primary care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(5).

7.13.10. All subcontracts executed by the MCO pursuant to this Section shall, at a minimum, include the terms and conditions listed in Section 25 of this RFP. No other terms or conditions agreed to by the MCO and its subcontractor shall negate or supersede the requirements in Section 25.

7.14. Credentialing and Re-credentialing of Providers and Clinical Staff

7.14.1. The MCO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230,

§455.103 and §455.105, and NCQA health plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted to DHH within sixty (60) calendar days after contract amendment, when a change is made, and annually thereafter by contract year.

7.14.1.1. Prior to subcontracting, the MCO shall follow DHH policy in requiring agencies offering Mental health rehabilitation services (CPST, PSR and/or CI), PRTFs, TGHs and SUD residential ~~addiction~~ treatment facilities to supply proof of accreditation or proof that the applicant applied for accreditation and paid the initial application fee for one of the national accreditation organizations listed below. New agencies must present proof of full accreditation within eighteen (18) months following the initial contracting date with:

- The Council on Accreditation (COA);
- The Commission on Accreditation of Rehabilitation Facilities (CARF); or
- The Joint Commission (TJC).

7.14.2. The MCO shall use the **Louisiana Standardized Credentialing Application Form** (Appendix F) or Council for Affordable Quality Healthcare (CAQH) standardized credentialing form. The MCO must allow providers to use CAQH if available for their provider type.

~~**7.14.1.**~~**7.14.3.** The MCO shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.

~~**7.14.2.**~~**7.14.4.** If the MCO has NCQA health plan Accreditation those credentialing policies and procedures shall meet DHH's credentialing requirements.

~~**7.14.3.**~~**7.14.5.** The MCO shall completely process credentialing applications from all types of provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. "Completely process" shall mean that the MCO shall:

~~**7.14.3.1.**~~**7.14.5.1.** Review, approve and load approved applicants to its provider files in its claims processing system; and

~~**7.14.3.2.**~~**7.14.5.2.** Submit on the weekly electronic Provider Directory to DHH or DHH's designee; or

~~**7.14.3.3.**~~**7.14.5.3.** Deny the application and assure that the provider is not used by the MCO.

7.14.6. If the MCO has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the contract.

The MCO must require that the subcontractor provide assurance that all licensed medical professionals are credentialed in accordance with DHH's credentialing requirements.

7.14.7. The MCO shall not delegate credentialing of specialized behavioral health providers unless approved by DHH in advance.

~~**7.14.4.**~~**7.14.8.** To the extent the MCO has delegated credentialing agreements in place with any approved delegated credentialing agency, the MCO shall ensure all providers submitted to the MCO from the delegated credentialing agent is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.

~~**7.14.5.**~~**7.14.9.** The MCO shall notify DHH when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

7.14.10. The process of periodic re-credentialing shall be completed at least once every three (3) years.

~~**7.14.6.**~~**7.14.11.** The MCO shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with the Contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.

~~**7.14.7.**~~**7.14.12.** The MCO shall develop and implement a mechanism, subject to DHH approval, for reporting quality deficiencies which result in suspension or termination of a network provider/subcontractor(s). This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.

~~**7.14.8.**~~**7.14.13.** The MCO shall develop and implement a provider dispute and appeal process, with DHH's approval, for sanctions, suspensions, and terminations imposed by the MCO against network provider/contractor(s) as specified in the Contract. This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.

~~**7.14.9.**~~**7.14.14.** The State reserves the right to contract with a single Credential Verification Organization (CVO). If this option is pursued, MCOs and their subcontractors shall agree to use the CVO for the credentialing and recredentialing of all participating providers. The MCO will be given at least 90 days' notice before implementation of any CVO contract.

7.15. Credentialing Committee

7.15.1. The MCO must designate a credentialing committee that uses a peer review process to evaluate provider credentialing files (including re-credentialing files). The credentialing committee, including the Medical Director, is responsible for credentialing decisions and is required to document its steps in the decision process and maintain individual provider files. A physician must oversee the credentialing committee.

7.15.1.1. Contracting of Behavioral Health Providers

7.15.1.1.1. The MCO shall enter into written subcontracts with qualified behavioral health service providers to deliver covered behavioral health services to members. The contract shall specify the activities and reporting responsibilities delegated to the provider; and provide for revoking delegation, terminating contracts, or imposing other sanctions if the provider's performance is inadequate.

7.15.1.1.2. Upon request, DHH shall be given copies of any subcontracts entered into by the MCO regarding behavioral health services, including provider subcontracts. Any proprietary information regarding rate setting may be redacted by the MCO.

7.15.1.1.3. All behavioral health provider subcontracts shall include the following provisions:

7.15.1.1.3.1. The name and address of the subcontracted behavioral health provider.

7.15.1.1.3.2. The method and amount of compensation, reimbursement, payment, and other considerations provided to the behavioral health provider.

7.15.1.1.3.3. Identification of the population to be served by the behavioral health provider, including the number of members the provider is expected to serve.

7.15.1.1.3.4. The amount, duration, and scope of covered behavioral health services to be provided.

7.15.1.1.3.5. The provider's treatment site shall be a smoke-free environment.

7.15.1.1.3.6. The term of the provider's subcontract, including beginning and ending dates, and procedures for extension, termination, and renegotiation.

7.15.1.1.3.7. The provider is responsible for ensuring any patient data (including data for the uninsured populations) required by the MCO is provided through an EHR interface or an ongoing data file submission.

7.15.1.1.3.8. Specific behavioral health provider subcontract duties relating to coordination of benefits and determination of third-party liability.

7.15.1.1.3.9. Identification of Medicare and other third-party liability coverage and requirements for seeking Medicare or third-party liability payments before submitting claims and/or encounters to MCO, when applicable.

7.15.1.1.3.10. Maintenance of an appropriate clinical record keeping system that ensures appropriateness of billing.

7.15.1.1.3.11. A requirement that contracted, allowable prescribing providers shall utilize the electronic Medicaid Clinical Data Inquiry (e-CDI) system (accessible via www.lamedicaid.com) to perform medication searches within the member's medical history to ensure that appropriate medication management is conducted.

7.15.1.1.3.12. Compliance with the requirements in the MCO QAPI and UM plans/program including PIP and Corrective Action Plans.

7.15.1.1.3.13. Language that requires a written contract amendment and prior approval of DHH, if the provider participates in any merger, reorganization, or changes in ownership or control, that is related to or affiliated with the MCO.

7.15.1.1.3.14. The HIPAA Business Associate Addendum.

7.15.1.1.3.15. Assumption of full responsibility for all tax obligations, worker's compensation insurance, and all other applicable insurance coverage obligations required in this contract, for itself and its employees, and that DHH shall have no responsibility or liability for any taxes or insurance coverage.

7.15.1.1.3.16. Incorporation by reference of the DHH Service Definitions Manual and the MCO's Provider Manual and language that the behavioral health provider subcontract complies with all requirements stated in this contract and CMS approved waiver and SPA.

7.15.1.1.3.17. A requirement that all behavioral health network providers request a standardized release of information from each member to allow the network provider to coordinate treatment with the member's primary care physician.

7.15.1.1.3.18. A requirement that the behavioral health provider notify the MCO when it is not accepting new clients, or if it does not accept a client and the associated cause.

7.15.1.1.3.19. Compliance with encounter reporting and claims submission requirements in accordance with this contract (to be detailed in the MCO's Provider Manual), including payment withhold provisions and penalties for non-reporting, untimely reporting, or inaccurate reporting.

7.15.1.1.3.20. A provision that the MCO will not offset DHH recouped payments on the behavioral health provider after DHH has verified that the MCO was at fault for the error in payment.

7.15.1.1.3.21. A requirement that behavioral health providers adopt the utilization management guidelines, and to measure compliance with the guidelines.

7.15.1.1.3.22. The right of a provider to appeal a claims dispute in accordance with this contract (to be detailed in the MCO's Provider Manual).

7.15.1.1.3.23. The provider shall be responsible for assisting members in understanding their right to file grievances and appeals in accordance with the MCO's Provider Manual. The MCO must provide the information specified at 42 C.F.R. §438.10(g)(1).

7.15.1.1.3.24. Compliance by the subcontractor with audits, inspections and reviews in accordance with the MCO's Provider Manual, including any reviews the MCO or DHH may conduct.

7.15.1.1.3.25. Facilitation by the provider of another provider's reasonable opportunity to deliver services, and the prohibition of any commission or condoning of any act or omission by the provider or by state employees that interferes with, delays, or hinders service delivery by another provider.

7.15.1.1.3.26. Compliance with adverse incident reporting policy and standards approved by DHH.

7.15.1.1.3.27. Timely implementation by the provider of DHH or MCO decisions related to grievances, member appeals, claims dispute or adverse incident mitigation recommendations.

7.15.1.1.3.28. Compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any behavioral health member, according to 42 CFR §438.12(e).

7.15.1.1.3.29. Submission to DHH and/or the MCO as determined by DHH of the NOMs, including access to services, engagement in services, independent and stable housing, employment, and employment training rates.

7.15.1.1.3.30. Members reaching the age of majority are provided continuity of care without service disruptions or mandatory changes in providers.

7.15.1.1.3.31. The DHH definition of medically necessary covered behavioral health services and the DHH levels of care are incorporated by reference.

7.15.1.1.3.32. A requirement that the providers assess the cultural and linguistic needs of the service area, and deliver services that address these needs to the extent resources are available.

7.15.1.1.3.33. A requirement that the providers attend trainings on cultural competence. The MCO shall include a cultural competency component in each training topic.

7.15.1.1.3.34. Language for supplying business transaction information upon request as required by 42 CFR §455.105. The credentialing forms and provider agreements used by the MCO will require network providers to disclose business transactions with wholly owned suppliers or any subcontractors upon request.

7.15.1.1.4. The MCO shall evaluate and make a determination to retain behavioral health providers utilizing performance and QI data acquired while delivering services under this contract.

7.15.1.1.5. The MCO shall clearly describe and disseminate the process and criteria to be used for terminating behavioral health provider participation. If the MCO declines to subcontract with individuals or groups of behavioral health providers as part of the network, it shall give the affected providers prior written notice of the reason for its decision.

7.15.1.1.6. The MCO shall give written notice of termination of a subcontract provider, within fifteen (15) calendar days after receipt of issuance of the termination notice, to each behavioral health member who received his or her care from or was seen on a regular basis by the terminated provider.

7.15.2. Credentialing and Contracting of Permanent Supportive Housing Providers

7.15.2.1. Because Louisiana's Permanent Supportive Housing program is a cross-disability program, MCO contracted providers delivering PSH services must meet the following requirements prior to, and as a condition of maintaining, contracting and credentialing to provide tenancy supports for PSH program participants:

7.15.2.1.1. Fulfill the orientation, training, and annual review requirements required and delivered through the DHH PSH program office;

7.15.2.1.2. Be approved for participation by the DHH PSH Program Director with oversight of the DHH PSH Executive Management Committee;

7.15.2.1.3. Meet all requirements necessary to maintain credentialing to provide CPST;

7.15.2.1.4. Enroll to provide housing support services under the applicable 1915(c) HCBS waiver programs in FFS Medicaid and/or managed long term supports and services.

7.15.2.2. The MCO shall offer a contract to all providers meeting the above requirements and approved by the DHH PSH Program Director to participate in the Louisiana PSH program. The contract must meet all rate floor requirements, unless other terms are agreed to by both parties.

7.15.2.3. The MCO shall accept provider credentialing requests, review them for completeness, forward the request to the DHH PSH program for review, approval of program participation, and maintain a roster and records of qualified PSH providers.

7.15.2.4. At the request of the DHH PSH program the MCO shall assist the DHH PSH program in PSH provider certification (fidelity) reviews, including the mutual sharing of MCO audit and PSH program monitoring reports for PSH providers.

7.15.2.5. At the request of the DHH PSH program, the MCO shall assist in advertising PSH provider orientation to interested providers in each region where there is a need to expand PSH as identified by the DHH PSH program.

7.15.3. Network Guidelines for Subcontracted Providers Needing DCFS Licensing

It is the MCO's responsibility to ensure its subcontracted providers comply with DCFS licensing requirements as applicable and can submit proof of compliance upon request. The MCO shall follow communication protocols as established by DCFS if necessary.

7.16. Provider-Member Communication Anti-Gag Clause

7.16.1. Subject to the limitations described in 42 CFR §438.102(a)(2), the MCO shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the Contract, for the following:

7.16.1.1. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

7.16.1.2. Any information the member needs in order to decide among relevant treatment options;

7.16.1.3. The risks, benefits and consequences of treatment or non-treatment; and

7.16.1.4. The member's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.

7.16.1.5. Any MCO that violates the anti-gag provisions set forth in 42 U.S.C §438.102(a)(1) shall be subject to intermediate sanctions.

7.16.1.6. The MCO shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.

7.17. Pharmacy Network, Access Standards and Reimbursement

7.17.1. Pharmacy Network Requirements

7.17.1.1. The MCO shall provide a pharmacy network that complies with DHH requirements but at a minimum includes only licensed and registered pharmacies that conform to the Louisiana Board of Pharmacy rules concerning the records to be maintained by a pharmacy.

7.17.1.2. No MCO may prohibit any pharmacy or pharmacist participating in the Medicaid program from contracting as a network provider provided the pharmacy or pharmacist is licensed and in good standing with the Louisiana State Board of Pharmacy and accepts the terms and conditions of the contract offered to them by the MCO.

7.17.1.3. The MCO must keep an up-to-date pharmacy provider directory on its website for public access. This directory must include, but not be limited to, the following information on all contracted network pharmacies:

7.17.1.3.1. Names, locations and telephone numbers.

7.17.1.3.2. Any non-English languages spoken.

7.17.1.3.3. Identification of hours of operation, including identification of providers that are open 24-hours per day.

7.17.1.3.4. Identification of pharmacies that provide vaccine services.

7.17.1.3.5. Identification of pharmacies that provide delivery services.

7.17.1.4. The MCO must make a hard copy of this directory available to its members upon request. The hard copy must be updated at least annually. The online version should be updated in real time, but no less than weekly.

7.17.1.5. The MCO shall ensure PBM/PBA has a network audit program that includes, at a minimum:

7.17.1.5.1. Random audits to determine provider compliance with the program policies, procedures and limitations outlined in the provider's contract. The MCO shall not utilize contingency-fee based pharmacy audits.

7.17.1.5.2. The MCO shall submit to DHH the policies of its audit program for approval.

7.17.1.6. The MCO shall ensure that Pharmacies submit the NPI of the prescriber on claims.

7.17.1.7. The MCO must educate network providers about how to access their formulary and PDL on their websites. The MCO must also provide provider education on claims processing and payment policies and procedures.

7.17.1.8. The MCO may negotiate the ingredient cost reimbursement in its contracts with providers. However, the MCO shall:

- Paypay a per-prescription dispensing fee, as defined in this contract, at a rate no less than $2.50 to all “local pharmacies” as defined in Act 399 of the 2015 Regular Session of the Louisiana Legislature;
- Add any state imposed provider fees for pharmacy services, on top of the minimum dispensing fee required by DHH;
- Update the . Iingredient costs of medications must be at least weekly;
- Make drug pricing list available to pharmacies for review;
- Afford individual pharmacies a chance to appeal inadequate reimbursement; and
- Provide for a “local pharmacy” appeals process in accordance with Act 399 of the 2015 Regular Session of the Louisiana Legislature.

7.17.1.9. The MCO and the PBM may not charge pharmacy providers claims processing or provider enrollment fees. This Section does not prohibit sanctioning pharmacy providers.

7.17.1.10. Thirty days after enrollment of a new MCO into Bayou Health, DHH will require that the MCO and PBM receive active agreement from pharmacy providers to participate in the MCO’s pharmacy network, even if the pharmacy provider has an existing relationship with the MCO’s PBM. This means that if a pharmacy provider is already contracted with an MCO’s PBM for other coverage products, notification alone will not be sufficient for that pharmacy provider to be considered part of the PBM’s Medicaid network. The pharmacy provider must actively agree to the terms of the Medicaid contract addendum.

7.17.2. Local Pharmacy Claims Dispute Management

The provisions of this section shall apply to dates of service on or after December 1, 2015.

7.17.2.1. Internal Claims Dispute Process

7.17.2.1.1. The MCO shall develop an internal claims dispute process to permit local pharmacies to dispute the reimbursement paid for any claim made for the dispensing of a drug.

7.17.2.1.2. A local pharmacy is defined as any pharmacy domiciled in at least one Louisiana parish that: contracts directly with the MCO or the MCO’s contractor in its own name or through a Pharmacy Services Administrative Organization (PSAO) and not under the authority of a group purchasing organization; and has fewer than ten retail outlets under the pharmacy’s corporate umbrella.

7.17.2.1.3. The MCO shall permit pharmacies to submit claim disputes directly to the MCO or through a PSAO at the pharmacy's option.

7.17.2.1.4. The MCO may require pharmacies to submit claim disputes within a predetermined time limit. Such limit shall be no less than seven (7) business days after the latter of the fill date or the resolution date of any pending AAC rate update request.

7.17.2.1.5. The MCO shall provide written notification of the outcome of the internal claims dispute process to the pharmacy within seven (7) business days of the date that the dispute was received by the MCO.

7.17.2.2. External Claims Dispute Process

7.17.2.2.1. The Department shall develop an external claims dispute process to permit local pharmacies to dispute the outcome of the internal claims dispute process.

7.17.2.2.2. The external claims dispute process shall serve as the final authority on local pharmacy claims disputes.

7.17.2.2.3. The Department shall define a reasonable reimbursement level to be used in the external claims dispute process. The Department may amend this definition unilaterally with sixty (60) calendar days' written notice to the MCO. Such notice shall include the revised definition and either an attestation that capitation rates remain actuarially sound or that actuarially sound capitation rates will be paid concurrent with implementation of the revised definition.

7.17.2.2.4. As specified in 7.15.1.8, MCOs shall reimburse pharmacies for any state imposed provider fees for pharmacy services. However, for purposes of the external claims dispute process, such fees shall be excluded from the definition of reasonable reimbursement.

7.17.2.2.5. The Department may require pharmacies to submit disputes of the outcome of the internal claims dispute process within fourteen (14) business days of the date of the written notification from the MCO of the outcome of the internal claims dispute process.

7.17.2.2.6. The Department shall provide written notification of the outcome of the external claims dispute process to the pharmacy and the MCO within seven (7) business days of the Department receipt.

7.17.2.2.7. If the Department determines that the disputed reimbursement was not reasonable, it shall require the MCO to provide the pharmacy an increased reimbursement to the Fee for Service Medicaid rate and shall require the MCO to update its payable price on file to reflect the increase. The price update shall be completed within seven (7) business days of written notification of the outcome of the external

claims dispute process to the MCO. All disputes that are submitted between the fill date of the original overturned dispute and the subsequent payable price file update shall be adjusted to the increased reimbursement.

7.17.2.3. Treatment of Excessive Disputes of Sufficiently Reimbursed Claims

7.17.2.3.1. If, within any thirty (30) calendar day period, a pharmacy has disputed claims across ten (10) or more drug entities with distinct pricing and for more than half of the disputes either the pharmacy declined to seek external review of the MCO's internal claims dispute process finding of reasonable reimbursement or the outcome of the external process was that the disputes were properly denied by the MCO on the basis of reasonable reimbursement, then the pharmacy shall be considered as having met the requirements for treatment of excessive disputes of reasonably reimbursed claims.

7.17.2.3.2. For pharmacies meeting such requirements, the MCO may dismiss all disputes submitted to the MCO for a sixty (60) calendar day period beginning on the date of the written notification of the outcome of the external dispute process for the claim that met requirements.

7.17.2.3.3. If the MCO implements this sixty (60) calendar day period, it must notify both the pharmacy and the Department within three (3) business days of such action and provide to the Department documentation demonstrating that the pharmacy has met the requirements for such treatment.

7.17.2.3.4. The MCO may pend reimbursement disputes submitted to the MCO's internal dispute process while awaiting the outcome of the external dispute process for the qualifying dispute.

7.17.2.3.5. Upon receipt of written notice of the outcome of the external claims dispute process wherein the internal dispute process outcome is in the pharmacy's favor, the MCO shall process pended disputes in order of receipt. For pended disputes, the seven (7) business days dispute resolution and notification requirement applicable to the internal claims dispute process shall begin on the date of the written notification of the outcome of external claims dispute process.

7.17.2.3.6. A pharmacy may be considered as meeting requirements for treatment of excessive disputes of sufficiently reimbursed claims anew every sixty (60) calendar days.

~~7.17.2.~~7.17.3. Mail Order/Mail Service Pharmacy

The MCO cannot require its members to use a mail service pharmacy. Mail order must not exceed more than one (1) percent of all pharmacy claims. Members cannot be charged anything above applicable copays (*e.g.* shipping and handling fees).

~~7.17.3.~~7.17.4. Specialty Drugs and Specialty Pharmacies

~~7.17.3.1.~~7.17.4.1. DHH recognizes the importance of providing adequate access to specialty drugs to Medicaid members while ensuring proper management of handling and utilization. For the purposes of this contract, "specialty drugs" shall be determined by the definition below. The MCO may limit distribution of specialty drugs from a network of specialty pharmacies that meet reasonable requirements to distribute specialty drugs and is willing to accept the terms of the MCO's agreement. DHH reserves the right to deny specialty pharmacy contracts that include what it deems to be overly burdensome terms or requirements, including but not limited to requirements for excessive insurance coverage, unreasonable stocking requirements, or restrictive or duplicative accreditation requirements.

A specialty drug is defined as one that is:

~~7.17.3.1.1.~~7.17.4.1.1. Not typically available at community retail pharmacies or under limited distribution per manufacturer/FDA; or

~~7.17.3.1.2.~~7.17.4.1.2. Includes at least two of the following characteristics:

7.17.3.2.2.1. Requires inventory management controls including but not limited to unique storage specifications, short shelf life, and special handling; or

7.17.3.2.2.2. Must be administered, infused or injected by a health care professional; or

7.17.3.2.2.3. The drug is indicated primarily for the treatment or prevention of:

- A complex or chronic medical condition, defined as a physical, behavioral or developmental condition that may have no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated, such as, but not limited to, multiple sclerosis, hepatitis C, cancer and rheumatoid arthritis; or

- A rare medical condition, defined as any disease or condition that typically affects fewer than 200,000 people in the United States; or

7.17.3.2.2.4. The total monthly cost is $3,000 or more.

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8.0 UTILIZATION MANAGEMENT

8.1. General Requirements

8.1.1. The MCO shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization. The MCO shall submit UM policies and procedures to DHH for written approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions.

8.1.2. The UM Program policies and procedures shall meet all NCQA standards and include medical management criteria and practice guidelines that:

8.1.2.1. Are adopted in consultation with contracting health care professionals;

8.1.2.2. Are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

8.1.2.3. Are considerate of the needs of the members; and

8.1.2.4. Are reviewed annually and updated periodically as appropriate.

8.1.3. The policies and procedures shall include, but not be limited to:

8.1.3.1. The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;

8.1.3.2. The data sources and clinical review criteria used in decision making;

8.1.3.3. The appropriateness of clinical review shall be fully documented;

8.1.3.4. The process for conducting informal reconsiderations for adverse determinations;

8.1.3.5. Mechanisms to ensure consistent application of review criteria and compatible decisions;

8.1.3.6. Data collection processes and analytical methods used in assessing utilization of health care services; ~~and~~

8.1.3.7. Provisions for assuring confidentiality of clinical and proprietary information;

8.1.3.8. Service authorization criteria for specialized behavioral health services that are consistent with the Medicaid State Plan;

8.1.3.9. Collaborating with OJJ, DCFS and schools to coordinate the discharge and transition of children and youth in out-of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including the referral to necessary providers or a WAA if indicated;

8.1.3.10. Collaborating with hospitals, nursing home facilities, and inpatient facilities to coordinate aftercare planning prior to discharge and transition of members for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers;

8.1.3.11. Collaborating with the Department of Corrections and criminal justice system in Louisiana to facilitate access to and/or continuation of prescribed medication and other behavioral health services prior to reentry into the community, including referral to community providers; and

~~8.1.3.7.~~**8.1.3.12.** Collaborating with nursing facilities in Louisiana to coordinate the discharge and transition of members into the community for continuance of prescribed medication and other behavioral health services prior to re-entry into the community, including referral to community providers.

8.1.4. The MCO shall coordinate the development of clinical practice guidelines with other DHH MCOs to avoid providers receiving conflicting practice guidelines from different MCOs.

8.1.5. The MCO shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.

8.1.5.1. The MCO shall take steps to require adoption of the clinical practice guidelines by subcontracted specialized behavioral healthcare providers, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers consistently achieve eighty percent (80%) compliance, based on MCO measurement findings. The MCO should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.

8.1.6. The MCO must identify the source of the medical management criteria used for the review of service authorization requests, including but not limited to:

8.1.6.1. The vendor must be identified if the criteria was purchased;

8.1.6.2. The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society;

8.1.6.3. The guideline source must be identified if the criteria are based on national best practice guidelines; and

8.1.6.4. The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the MCO medical director or other qualified and trained professionals.

8.1.7. UM Program medical management criteria and practice guidelines shall be disseminated to all affected providers, members and potential members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.

8.1.8. The MCO shall have written procedures listing the information required from a member or health care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall outline the process to be followed in the event the MCO determines the need for additional information not initially requested.

8.1.9. The MCO shall have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the MCO may deny authorization of the requested service(s) within two (2) business days.

8.1.10. The MCO shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines. The MCO shall provide UM staff specifically assigned to:

8.1.10.1. Specialized behavioral health services, and

8.1.10.2. PSH to ensure appropriate authorization of tenancy services.

8.1.11. The MCO shall use DHH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations. The MCO shall make medical necessity determinations that are consistent with the State's definition.

8.1.12. The MCO shall submit written policies and procedures for DHH approval, within thirty (30) days of the contract being signed by the MCO, addressing how the core benefits and services ensure:

8.1.12.1. The prevention, diagnosis, and treatment of health impairments;

8.1.12.2. The ability to achieve age-appropriate growth and development; and

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

8.1.13. The MCO must identify the qualification of staff who will determine medical necessity.

8.1.14. Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.

8.1.15. The MCO shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

8.1.16. The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.

8.1.17. The individual making these determinations is required to attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.

8.1.18. The MCO shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The MCO shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The MCO may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.

8.1.19. The MCO shall conduct utilization management and review functions which include:

8.1.19.1. Apply initial risk screen for CSoC eligibility,

8.1.19.2. Refer calls (via a seamless "warm transfer") to the contracted administrator of CSoC program, who will apply Brief CANS assessment tool to assess for CSoC presumptive eligibility.

8.1.19.3. Document in the child's health record whether or not (according to CSoC contracted administrator) the child met criteria for CSoC presumed eligibility, when the child was referred to the WAA, and the date on which the Freedom of Choice (FOC) was signed.

8.1.19.4. The MCO shall also document in the child's health record if the child does not become enrolled in CSoC, for the reasons of 1) the youth and family refuse CSoC services, or 2) the youth does not meet clinical eligibility based on the comprehensive CANS, or for any other reason.

8.1.19.5. For youth who screened positively on the initial risk screen, but who do not complete enrollment in CSoC, the MCO shall offer voluntary participation in the Case Management Program, and/or other behavioral health services to meet the child and family's presenting needs.

8.1.20. Upon request, the MCO shall provide the PASRR Level II authority (OBH) with documentation supporting appropriate limits on a service on the basis of medical necessity for individuals determined by the PASRR Level II authority to need specialized behavioral health services.

~~**8.1.19.**~~**8.1.21.** The MCO shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.

~~**8.1.20.**~~**8.1.22.** The MCO shall report fraud and abuse information identified through the UM program to DHH in accordance with 42 CFR §455.1(a)(1).

~~8.1.21.~~8.1.23. In accordance with 42 CFR §456.111 and §456.211, the MCO Utilization Review (UR) plan must provide that each enrollee's record includes information needed for the UR committee to perform UR required under this Section. This information must include, at least, the following:

~~8.1.21.1.~~8.1.23.1. Identification of the enrollee;

~~8.1.21.2.~~8.1.23.2. The name of the enrollee's physician;

~~8.1.21.3.~~8.1.23.3. Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;

~~8.1.21.4.~~8.1.23.4. The plan of care required under 42 CFR §456.80 and §456.180;

~~8.1.21.5.~~8.1.23.5. Initial and subsequent continued stay review dates described under 42 CFR §456.128, §456.133, §456.233 and §456.234;

~~8.1.21.6.~~8.1.23.6. Date of operating room reservation, if applicable; and

~~8.1.21.7.~~8.1.23.7. Justification of emergency admission, if applicable.

8.2. Utilization Management Committee

8.2.1. The Utilization Management (UM) program shall include a UM Committee that integrates with other functional units of the MCO as appropriate and supports the quality assessment and performance improvement program (QAPI) Program (refer to the Quality Management subsection for details regarding the QAPI Program).

8.2.2. The UM Committee shall provide utilization review and monitoring of UM activities of both the MCO and its providers and is directed by the MCO Medical Director. The UM Committee shall convene no less than quarterly and shall make meeting minutes available to DHH upon request. DHH representatives, as appointed by DHH, shall be included as members of the UM Committee, if requested. UM Committee responsibilities include:

8.2.2.1. Monitoring providers' requests for rendering healthcare services to its members;

8.2.2.2. Monitoring the medical appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling;

8.2.2.3. Reviewing the effectiveness of the utilization review process and making changes to the process as needed;

8.2.2.4. Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;

8.2.2.5. Monitoring consistent application of "medical necessity" criteria;

8.2.2.6. Application of clinical practice guidelines;

8.2.2.7. Monitoring over- and under-utilization;

8.2.2.8. Review of outliers, and

8.2.2.9. Medical Record Reviews - reviews of member medical records shall be conducted to ensure that PCPs provide high quality health care that is documented according to established standards.

- **Medical and Treatment Record Review Strategy**

  - The MCO shall maintain a written strategy for conducting medical record reviews, reporting results and the corrective action process. The strategy shall be provided within thirty (30) days from the date the Contract is signed and annually thereafter. The strategy shall include, at a minimum, the following:

    – Designated staff to perform this duty;

    – The method of case selection;

    – The anticipated number of reviews by practice site;

    – The tool the MCO shall use to review each site; and

    – How the MCO shall link the information compiled during the review to other MCO functions (*e.g.* QI, credentialing, peer review, etc.); and .)

    – Schedule of reviews by provider type.

  - The standards, which shall include all medical record documentation requirements addressed in the Contract, shall be distributed to all providers.

8.2.3. The MCO shall conduct reviews at all PCP sites with fifty (50) or more linked members and practice sites which include both individual offices and large group facilities. The MCO shall review each site at least one (1) time during each two (2) year period.

8.2.4. The MCO shall conduct reviews at all LMHP sites serving fifty (50) or more members and practice sites which include both individual offices and large group facilities. The MCO shall review each site at least one (1) time during each two (2) year period.

8.2.5. The MCO shall review a reasonable number of records at each site to determine compliance. Five (5) to ten (10) records per site is a generally accepted target. For large group practices (six or more providers in the group), three record reviews per provider shall be required.

8.2.6. The MCO shall report the results of all medical and treatment record reviews to DHH quarterly with an annual summary.

8.3. Utilization Management Reports

The MCO shall submit utilization management reports as specified by DHH. DHH reserves the right to request additional reports as deemed by DHH. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports

8.4. Service Authorization

8.4.1. Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization. (For Pharmacy Service Authorizations see Section 8.6.)

8.4.2. The MCO UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210, 42 CFR §441 Subpart D, ~~and~~ state laws and regulations, Medicaid State Plan and waivers, and the court-ordered requirements of *Chisholm v. Kliebert* and *Wells v. Kliebert* for initial and continuing authorization of services that include, but are not limited to, the following:

8.4.2.1. Written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization member's request is for the provision of a service if a provider refuses a service or does not request a service in a timely manner;

8.4.2.2. Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;

8.4.2.3. Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease;

8.4.2.4. Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures;

8.4.2.5. The MCO's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and

8.4.2.6. The MCO's service authorization system shall have capacity to electronically store and report the time and date all service authorization requests are received, decisions made by the MCO regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.

8.4.3. The MCO shall not deny continuation of higher level services (*e.g.,* inpatient hospital) for failure to meet medical necessity unless the MCO can provide the service through an in-network or out-of-network provider for a lower lever care.

8.4.4. The MCO shall perform prior authorization and concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals.

8.4.4.1. The MCO shall ensure that inpatient psychiatric hospital and concurrent utilization reviews are completed by an LMHP for each enrollee referred for psychiatric admissions to general hospitals. The MCO shall comply with the requirements set forth in the Inpatient Psychiatric Services Rule [Louisiana Register, Vol. 21, No. 6, Page 575].

8.4.4.2. Concurrent utilization reviews are administrative in nature and should not be reported to DHH in encounter data. These reviews are not considered prior authorizations because inpatient reimbursement is not edited against the utilization review prior to payment. Also, there are instances where individuals personally presenting at the inpatient psychiatric hospital may be admitted by hospital staff. However, DHH does reserve the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment.

8.4.4.3. Concurrent utilization review includes:

- Provision of Emergency Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric treatment. The individual is in crisis and not currently in a place of safety. If the individual presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent, as the person needs to be seen right away to determine appropriate treatment. The referral from the MCO for an Emergency Inpatient Psychiatric Hospital Screen shall be made immediately. The screen to determine appropriate treatment shall be completed within one hour after request is received by an emergency room for post-stabilization treatment or three hours after receipt of the request in other circumstances. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, the procedures specified below should be utilized.

- Provision of an Urgent Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening is initiated if the individual meets one criterion specified on the state approved screening form and is currently in a place of safety. If the member presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent and follow the protocols and timeframes specified above. If the member presents at a hospital with a psychiatric unit or trained psychiatric personnel, and is admitted by the treating physician, then it will be classified as an urgent screen. The referral from the MCO for an Urgent Inpatient Psychiatric Hospital Screen shall be made within 24 hours after the referral and full medical information is received by MCO. The screen to determine appropriate treatment shall be completed within 24 hours of the MCO's referral after the referral and full medical information is received by MCO. If psychiatric residential treatment is recommended, in

lieu of inpatient psychiatric hospitalization, due to concerns regarding the safety of a child/youth, the procedures specified above should be utilized.

- Upon completion of the Inpatient Psychiatric Hospital Concurrent Utilization Review, if the inpatient admission is approved, the MCO shall notify the provider and individual requesting the screen of the results in writing within 48 hours of receipt of the request by the MCO. If denied, the MCO shall notify the individual requesting the screen immediately, and within 48 hours of receipt of the request by the MCO provide written notification of the results to the provider and individual requesting the screen. The notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal and the process to do so.

8.4.4.4. Certification of Need for PRTFs

8.4.4.4.1. The MCO shall comply with the requirements set forth at 42 CFR §441 Subpart D.

8.4.4.4.2. The MCO shall ensure LMHPs are included in the team responsible for certification and recertification of PRTF services in Louisiana. This shall include a face-to-face assessment by an LMHP or a telephonic/video consultation with an LMHP who has had a face-to-face interview with the child/youth, in addition to the recommendations of a team specified at 42 CFR §441.154.

8.4.4.4.3. The MCO may use an LMHP/team composed of the MCO's staff or the MCO may subcontract with an LMHP. To ensure the team has knowledge of the ambulatory resources available to the youth and the youth's situation, the MCO shall ensure that the team is assembled by a subcontract in the child's/youth's parish of residence or adjacent parish (if not in state custody) or the child's/youth's parish or adjacent parish of responsibility (if in state custody).

8.4.4.4.4. Recertification shall occur every sixty (60) calendar days. For the PRTF screens to be complete, the team shall meet and rule out other community based options. This does not apply to other inpatient screens.

8.4.4.4.5. In addition to certifying the need, the MCO shall:

- Be responsible for tracking the member's authorization period for PRTF stays and providing notification to the responsible party when a recertification is due.
- Ensure that PRTF certification, including the independent certification, are forwarded to the admitting facility.
    - Upon completion of the certification of need, if the PRTF is approved, within 48 hours, the MCO shall notify in writing, the provider requesting the certification of the results. If denied, the MCO shall notify the provider requesting the certification immediately and, within 48 hours, provide written notification to the provider requesting the certification of the results. The

notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal, and the process to do so.

- o Generate a prior authorization for each PRTF admission within 48 hours of completion of the screen.
- o Accurately determine admissions and discharges to PRTFs and perform PRTF-specific eligibility functions.
- o Work with the Medicaid FI to determine retroactive eligibility and assignment, when applicable.
- o Maintain near real time bed utilization/availability and manage a waiting list for PRTF placement including out-of-state replacements.

8.4.5. At such time Therapeutic Foster Care (TFC) is added to the Medicaid benefit, the MCO shall work with DHH to develop prior authorization and concurrent utilization review for that service. MCOs may use the Service Definition Manual or other approved Medical Necessity Criteria for Therapeutic Group Homes and other residential levels of care.

8.5. Timing of Service Authorization Decisions

8.5.1. Standard Service Authorization

8.5.1.1. The MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.

8.5.1.2. The MCO shall make ninety-five percent (95%) of concurrent review determinations within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required.

8.5.2. Expedited Service Authorization

8.5.2.1. In the event a provider indicates, or the MCO determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.

8.5.2.2. The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the MCO justifies to DHH a need for additional information and how the extension is in the member's best interest.

8.5.3. Post Authorization

8.5.3.1. The MCO shall make retrospective review determinations within thirty (30) days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.

8.5.3.2. The MCO shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.

8.5.4. Timing of Notice

8.5.4.1. Notice of Action

8.5.4.1.1. Approval

8.5.4.1.1.1. For service authorization approval for a non-emergency admission, procedure or service, the MCO shall notify the provider verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.

8.5.4.1.1.2. For service authorization approval for extended stay or additional services, the MCO shall notify the provider rendering the service, whether a health care professional or facility or both, and the member receiving the service, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.

8.5.4.1.2. Adverse

8.5.4.1.2.1. The MCO shall notify the member, in writing using language that is easily understood by the member, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in Section 13 of this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210, Section 12 of this RFP for member written materials, and any agreements that the Department may have entered into relative to the contents of member notices of denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out-of-court settlements.

8.5.4.1.2.2. The MCO shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an

amount, duration, or scope that is less than requested. The MCO shall notify the notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.

8.5.4.1.3. Informal Reconsideration

8.5.4.1.3.1. As part of the MCO appeal procedures, the MCO should include an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

8.5.4.1.3.2. In a case involving an initial determination or a concurrent review determination, the MCO should provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [§438.402(b)(ii)].

8.5.4.1.3.3. The informal reconsideration should occur within one (1) working day of the receipt of the request and should be conducted between the provider rendering the service and the MCO's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) working day.

8.5.4.1.3.4. The Informal Reconsideration will in no way extend the thirty (30) day required timeframe for a Notice of Appeal Resolution.

8.5.4.2. Exceptions to Requirements

- The MCO shall not require service authorization for emergency services or post-stabilization services as described in this Section whether provided by an in-network or out-of-network provider.
- The MCO shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.
- The MCO shall not require service authorization or referral for EPSDT screening services.
- The MCO shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider, however, the MCO may require prior authorization of services beyond thirty (30) calendar days.

- The MCO is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first 30 days of a newly enrolled members linkage to the plan.

- The MCO shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the MCO for routine and preventive women's healthcare services and prenatal care.

- The MCO shall not require a PCP referral for in-network eye care and vision services.

- The MCO may require notification by the provider of Obstetrical care at the time of the first visit of the pregnancy.

- The MCO may require notification by the provider of Obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery. The MCO is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of Obstetrical admission exceeding forty-eight (48) hours after vaginal delivery. In this case, the MCO is allowed to deny only the portion of the claim related to the inpatient stay beyond forty-eight (48) hours.

- The MCO may require notification by the provider of Obstetrical admissions exceeding ninety-six (96) hours after Caesarean section. The MCO is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of Obstetrical admission exceeding ninety-six (96) hours after Caesarean section. In this case, the MCO is allowed to deny only the portion of the claim related to the inpatient stay beyond ninety-six (96) hours.

- The MCO may require notification by the provider of inpatient emergency admissions within one (1) business day of admission. The MCO is allowed to deny a claim for payment based solely on lack of notification of inpatient emergency admission, if the provider does not notify the MCO of inpatient emergency admission within one (1) business day of admission.

8.6. Service Authorization Pharmacy Services

8.6.1. Prior authorization may be used for drug products under the following conditions:

8.6.1.1. When prescribing medically necessary non-Formulary or non-preferred (non PDL) drugs.

8.6.1.2. When prescribing drugs inconsistent with FDA approved labeling, including behavioral health drugs. When prescribing is inconsistent with nationally accepted guidelines.

8.6.1.3. When prescribing brand name medications which have A-rated generic equivalents.

8.6.1.4. To minimize potential drug over-utilization.

8.6.1.5. To accommodate exceptions to Medicaid drug utilization review standards related to proper maintenance drug therapy.

8.6.2. DHH may ~~prohibit~~ require prior authorization overrides for selected drug products or devices at its discretion.

8.6.3. Prior authorization shall be automatically approved upon notification to the plan by the prescriber's office for a dosage change for any medications in behavioral health therapeutic classes (including long-acting injectable antipsychotics) and other medication assisted treatment (including Suboxone and Naloxone), that have been previously authorized and/or approved within current health plan for any member with a behavioral health or substance use disorder diagnosis, as long as the newly prescribed dose is within established FDA guidelines for that medication.

8.6.4. Any prior approval issued by the MCO shall take into consideration prescription refills related to the original pharmacy service. The MCO must notify the requesting practitioner of the approval or disapproval of the request within 24 hours once relevant medically necessary information is obtained from the prescriber.

8.6.5. The MCO must provide access to a toll-free call center for prescribers to call to request prior authorization for non-preferred drugs or drugs that are subject to clinical edits. The MCO must allow prescribers and pharmacies to submit prior authorization requests by phone, fax or automated process. If the MCO or its pharmacy benefit manager operates a separate call center for prior authorization requests, it will be subject to the provider call center standards set forth in Section 10 of this contract and monetary penalties set forth in Section 20 of this contract.

8.6.6. The MCO shall not penalize the prescriber or enrollee, financially or otherwise, for such requests and approvals.

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

8.6.8. An enrollee receiving a prescription drug that was on the MCO's Formulary or PDL and subsequently removed or changed, shall be permitted to continue to receive that prescription drug if determined to be medically necessary for at least sixty (60) days. The MCO must make that determination in consultation with the prescriber.

8.6.9. If a prescription for a medication is not filled when the prescription is presented to the pharmacy due to a prior authorization requirement, the MCO must have an automated process that allows the pharmacy to dispense up to a 72-hour supply of a product or full unbreakable packages without having to obtain an override. The pharmacy may fill consecutive 72-hour supplies if the prescriber remains unavailable but the MCO is only required to pay one dispensing fee. The MCO must reimburse the pharmacy for dispensing the temporary supply of medication.

8.6.10. A member, or a provider on Member's behalf, may appeal prior authorization denials in accordance with Section 13 (Grievances and Appeals) of this contract.

8.7. Step Therapy and/or Fail First Protocols

The MCO is allowed to implement step therapy or fail first protocols to first drive utilization toward the most cost-effective and safest drug therapy. These protocols may be applied to either individual drugs or classes of drugs. However, the MCO must provide a clear process for a provider to request an override of such restrictions. An override shall be granted when the prescribing physician can demonstrate, based on sound clinic evidence, that the preferred treatment required under the step therapy or fail first protocol: (1) has been ineffective in the treatment of the Medicaid enrollee's disease or medical condition; (2) will be expected to be ineffective based on the known relevant physical or mental characteristics and medical history of the Medicaid enrollee and known characteristics of the drug regimen; or (3) will cause or will likely cause an adverse reaction or other physical harm to the Medicaid enrollee.

8.8. Medication Therapy Management

8.8.1. Within 90 days of implementation, the MCO is required to implement a Medication Therapy Management (MTM) program. The MTM program should include participation from community pharmacists, and include both in-person and telephonic interventions with trained clinical pharmacists.

8.8.2. Reimbursement for MTM services with participating pharmacists should be separate and above dispensing and ingredient cost reimbursement.

8.8.3. These programs should be developed to identify and target members who would most benefit from these interactions. They should include coordination between the MCO, the member, the pharmacist and the prescriber using various means of communication and education.

8.9. Lock-In (Restriction) Program

8.9.1. The MCO may implement a restriction program including policies, procedures and criteria for establishing the need for the lock-in, which must be prior approved by DHH.

8.9.2. Lock-in is a mechanism for restricting Medicaid recipients to a specific physician and/or a specific pharmacy provider. The lock-in mechanism does not prohibit the recipient from receiving services from providers who offer services other than physician and pharmacy benefits.

8.9.3. The lock-in mechanism must:

- Ensure appropriate use of Medicaid benefits by recipients and/or providers; and
- Serve as an educational and monitoring parameter in instructing recipients in the most efficient method of using Medicaid services to ensure maximum health benefits.

8.9.4. A Medicaid recipient who has shown a consistent pattern of misuse or overuse of program benefits may be placed into the lock-in mechanism by the MCO. Misuse and overuse is a determination made by the MCO. The MCO shall submit for approval to DHH a list of criteria for which a member may be restricted. Misuse and overuse can occur in a variety of ways.

8.9.5. Misuse may take the form of obtaining prescriptions under the pharmacy program from various prescribers and/or pharmacies in an uncontrolled and unsound way.

8.9.6. Misuse may take the form of obtaining prescriptions or the dispersal of prescriptions by fraudulent actions.

8.9.7. In its Lock-In program, the MCO should abide by the following protocols:

8.9.7.1. Enrollees shall be notified prior to the lock-in and must be permitted to change providers for good cause. A seventy-two (72)-hour emergency supply or a full unbreakable package of medication at pharmacies other than the designated lock-in pharmacy shall be permitted to ensure the provision of necessary medication required in an interim/urgent basis when the assigned pharmacy does not immediately have the medication.

8.9.7.2. The MCO shall initiate contact with the recipient in instances when the recipient fails to contact the MCO.

8.9.7.3. MCO shall notify the recipient and the prescribers of the intent to enroll a recipient in the Pharmacy Lock-In Program or the Physician-Pharmacy Lock-In Program. The plan shall notify the recipient of their intent to lock-in the recipient to a pharmacy and/or physician provider. In the case of Pharmacy-Only Lock-In, the recipient will be given a list of three potential Lock-In pharmacies and asked to select one pharmacy. The pharmacy selection will be reviewed and deemed acceptable by the MCO before notifying the recipient of potential lock-in enrollment. Recipients will always be notified of their rights and responsibilities to appeal enrollment in a Lock-In Program.

8.9.7.4. The MCO shall notify lock-in providers of their selection.

8.9.7.5. The continued need for lock-in shall be periodically (at least every two (2) years) evaluated by the MCO for each member in the program. Prescriptions from all participating prescribers shall be honored and may not be required to be written by the PCP only unless the member is also locked in to his/her PCP.

8.9.7.6. The MCO shall submit monthly reports within ten (10) days after the last day of the month on the pharmacy lock-in program activities as defined by DHH. The MCO shall transmit a monthly file to DHH identifying the recipients that are enrolled in Physician and Pharmacy Lock-In and those enrolled in Pharmacy-Only Lock-In. This can be a one byte field. In addition to the Lock-In recipients, the MCO shall also lock in providers that manage the recipients.

8.9.7.7. The MCO shall develop criteria and protocols to avoid enrollee injury due to the prescribing of drugs by more than one prescriber.

8.10. Pharmacy Administrative Simplification

Not later than September 30, 2015, the MCO shall develop jointly with all other Bayou Health MCOs a common pharmacy administrative framework that applies equally to each Bayou Health MCO and collectively meets the requirements of Sections 6.3.1 through 6.3.5.3. The framework and any revision thereto, shall be reviewed and approved by DHH prior to implementation. Any changes to the framework shall be submitted to DHH at least 30 days prior to implementation.

8.11. Medical History Information

8.11.1. The MCO is responsible for eliciting pertinent medical record information from the treating health care provider(s), as needed and/or as requested by DHH, for purposes of making medical necessity determinations.

8.11.2. The MCO shall take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe.

8.11.3. Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, shall not be entitled to payment for the provision of such item or service.

8.11.4. Should a provider fail or refuse to respond to the MCO's request for medical record information, at the MCO's discretion or directive by DHH, the MCO shall, at a minimum, impose financial penalties against the provider as appropriate.

8.12. PCP and Behavioral Health Provider Utilization and Quality Profiling

8.12.1. The MCO shall profile its PCPs and specialized behavioral health providers (including but not limited to addiction, mental health, and residential providers) and analyze utilization data to identify utilization~~PCP Utilization~~ and/or quality of care issues.

8.12.2. The MCO shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.

8.12.3. The MCO shall submit individual PCP and specialized behavioral health provider profile reports to DHH quarterly. MCO provider~~PCP~~ profiling activities shall include, but are not limited to, the following:

8.12.3.1. Utilization of out-of-network providers – The MCO shall maintain a procedure to identify and evaluate member out-of-network provider referral utilization by its PCP panel;

8.12.3.2. Specialist referrals – The MCO shall maintain a procedure to identify and evaluate member specialty provider referral utilization by its PCP panel;

8.12.3.3. Emergency department utilization – The MCO shall maintain a procedure to identify and evaluate member emergency department referral utilization by its provider~~PCP~~ panel;

8.12.3.4. Hospital admits, lab services, medications, and radiology services – The MCO shall maintain a procedure to identify and evaluate member's utilization; and

8.12.3.5. Individual providerPCP clinical quality performance measures as indicated in Appendix J.

8.13. PCP and Behavioral Health ProviderPCP Utilization & Quality Profile Reporting Requirements

The MCO shall submit profile reports quarterly with an Annual Summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.

8.14. Drug Utilization Review (DUR) Program

The MCO shall establish and maintain a drug utilization review (DUR) program that satisfies the minimum requirements for prospective and retrospective DUR as described in Section 1927(g) of the Social Security Act.

8.14.1. The MCO shall include review of Mental Health/Substance Abuse (MH/SA) drugs in its DUR program.

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

8.14.3. The MCO shall implement an online claims adjudication system, which shall include a prospective review of drug utilization, and include age-specific edits where appropriate.

8.14.4. The prospective and retrospective DUR standards established by the MCO shall be consistent with those same standards established by DHH.

8.14.5. The MCO's DUR program shall include the standards for each category of DUR, *i.e.*, therapeutic duplication, drug-drug interaction, maximum daily dosage and therapy duration.

8.14.6. The MCO's DUR program shall include a procedure/process for utilization review for each category of DUR.

8.14.7. DHH shall review and approve the MCO's DUR policy and procedures, DUR utilization review process/procedure and the standards included therein, and any revisions. The DUR program and revisions must be submitted to DHH for prior approval at least forty-five (45) days in advance of the proposed effective date.

8.15. Court-Ordered Assessment, Treatment, and Placement which Challenge Medical Necessity Determination and Defensible Lengths of Stay

8.15.1. All court-ordered Medicaid behavioral health services are subject to medical necessity review. In order to be eligible for payment, the service must be medically necessary and a covered benefit/service, as determined by the MCO

within Louisiana Medicaid's medical necessity definition and are subject to medical necessity review.

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9.0 PROVIDER REIMBURSEMENT

The MCO shall administer an effective, accurate and efficient claims processing system that adjudicates provider claims for covered services that are filed within the time frames specified by this Section and in compliance with all applicable State and Federal laws, rules and regulations.

The system shall have the capacity to group claims and to reimburse inpatient hospital services under a Diagnosis Related Grouping (DRG) methodology as defined by DHH within 180 days of notification by DHH that such reimbursement method is required.

9.1. Minimum Reimbursement to In-Network Providers

9.1.1. The MCO shall provide reimbursement for defined core benefits and services provided by an in-network provider. The MCO rate of reimbursement shall be no less than the published Medicaid fee-for-service rate in effect on the date of service or its equivalent (such as a DRG case rate), unless mutually agreed to by both the plan and the provider in the provider contract. DHH shall retain responsibility for setting and defining minimum provider rates for Medicaid covered services.

Note: For providers who receive cost-based reimbursement (cost settlement and outliers) for Medicaid services, the published Medicaid fee-for-service rate shall be the rate that would be received in the fee-for-service Medicaid program. Hereafter in this Section, unless otherwise specified, the above reimbursement arrangement is referred to as the "Medicaid rate." DHH will notify MCOs of updates to the Medicaid fee schedule and payment rates.

9.2. FQHC/RHC Contracting and Reimbursement

9.2.1. The MCO shall reimburse contracted FQHC/RHC the Prospective Payment System (PPS) rate in effect on the date of service for each encounter.

9.2.2. The MCO shall not enter into alternative reimbursement arrangements with FQHCs or RHCs without written prior approval from DHH.

9.2.3. If an MCO is unable to contract with an FQHC or RHC, the MCO is not required to reimburse that FQHC or RHC without prior approval for out-of-network services unless:

9.2.3.1. The medically necessary services are required to treat an emergency medical condition; or

9.2.3.2. FQHC/RHC services are not available through at least one MCO within DHH's established distance travel standards.

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9.2.3.3. The MCO may stipulate that reimbursement will be contingent upon receiving a clean claim and all the medical information required to update the member's medical record.

9.2.3.4. The MCO shall inform members of these rights in their member handbooks.

9.3. Reimbursement to Out-of-Network Providers

9.3.1. The MCO shall make payment for covered emergency and post-stabilization services that are furnished by providers that have no arrangements with the MCO for the provision of such services. The MCO shall reimburse the provider one hundred percent (100%) of the Medicaid rate for emergency services. In compliance with Section 6085 of the Deficit Reduction Act (DRA) of 2005, reimbursement by the MCO to out-of-network providers for the provision of emergency services shall be no more than the Medicaid rate.

9.3.2. For services that do not meet the definition of emergency services, the MCO is not required to reimburse more than 90% of the published Medicaid rate in effect on the date of service to out-of-network providers to whom they have made at least three (3) documented attempts (as defined in Glossary) to include the provider in their network (except as noted in Section 9.2). The MCO may require prior authorization of out-of network services, unless services are required to treat an emergency medical condition.

9.4. Effective Date of Payment for New Members

The MCO is responsible for payment of core benefits and services from the effective date of a member's eligibility for Louisiana Medicaid. This includes reimbursement to a member for payments already made by the member for Medicaid payable services during the retroactive eligibility period. The date of enrollment in an MCO will match the Medicaid eligibility effective date and may be retroactive for a period not to exceed 12 months.

9.5. Claims Processing Requirements

9.5.1. At a minimum, the MCO shall run one (1) provider payment cycle per week, on the same day each week, as determined by the MCO

9.5.2. The MCO shall support a CAQH/CORE compliant interface to the automated clearinghouse (ACH) that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

9.5.3. The MCO shall encourage that its providers, as an alternative to the filing of paper-based claims, submit and receive claims information through electronic data interchange (EDI).

9.5.4. Claims must be processed in adherence to information exchange and data management requirements specified in Section 17 of this RFP.

9.5.5. The MCO shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid or SCHIP programs for fraud, abuse or waste or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employs someone on this list. The MCO shall not pay any claim submitted by a provider that is on payment hold under the authority of DHH or its authorized agent(s).

9.5.6. The MCO shall inform all network Providers about Clean Claim requirements at least thirty (30) Calendar Days prior to the Operational Start Date. The MCO shall make available to network Providers requirements and guidelines for claims coding and processing that are specific to Provider types. The MCO shall notify

Providers ninety (90) Calendar Days before implementing changes to Claims coding and processing guidelines.

9.5.7. In addition to the specific Web site requirements outlined above, the MCOs Web site shall be functionally equivalent to the Web site maintained by the DHH FI.

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

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

9.5.8.2. If the MCO is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting member roster information from DHH.

9.6. Inappropriate Payment Denials

If the MCO has a pattern of inappropriately denying or delaying provider payments for services, the MCO may be subject to suspension of new enrollments, sanctions, contract cancellation, or refusal to contract in a future time period. This applies not only to situations where DHH has ordered payment after appeal but to situations where no appeal has been made (i.e. DHH is knowledgeable about the documented abuse from other sources).

9.7. Payment for Emergency Services and Post-stabilization Services

9.7.1. The MCO shall reimburse providers for emergency services rendered without a requirement for service authorization of any kind.

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

9.7.3. The MCO may not limit what constitutes an emergency medical condition on the basis of diagnoses or symptoms.

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

9.7.5. The MCO shall not deny payment for treatment obtained when a member had an emergency medical condition including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of emergency medical condition.

9.7.6. The MCO may, however, enter into contracts with providers or facilities that require, as a condition of payment, the provider or facility to provide notification to the MCO within a minimum of ten (10) calendar days after members are present at the ED, assuming adequate provision is given for such notification. The policy for non-payment must be included in the MCO Provider Manual.

9.7.7. The MCO shall be financially responsible for emergency medical services, including transportation, and shall not retroactively deny a claim for emergency services, including transportation, to an emergency provider because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, was subsequently determined to be non-emergency in nature.

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

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

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

- Administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services;
- Administered to maintain, improve or resolve the member's stabilized condition if the MCO:
    - Does not respond to a request for pre-approval within one (1) hour;
    - Cannot be contacted; or
    - MCO's representative and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of 42 CFR §422.133(c)(3) is met.
- Are for post-stabilization hospital-to-hospital ambulance transportation of members with a behavioral health condition, including hospital to behavioral health specialty hospital.

9.7.9. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO as responsible for coverage and payment as per 42 CFR §438.114(d). The MCO's financial responsibility ends for post stabilization care services it has not pre-approved when:

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

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

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

9.7.9.4. The member is discharged.

9.7.10. Expenditures for the medical services as previously described have been factored into the capitation rate described in Section 5.0 of this RFP and the MCO will not receive any additional payments.

9.8. Physician Incentive Plans

9.8.1. In accordance with 42 CFR §422.208 and §422.210, the MCO may operate a Physician Incentive Plan, but specific payment cannot be made directly or indirectly under a Physician Incentive Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

9.8.2. The MCO's incentive plans for its network providers/subcontractors shall be in compliance with 42 CFR §438.6(h), §422.208 and §422.210. (See Appendix Q, **Requirements for MCO Physician Incentive Plans**).

9.8.3. Any sub-capitation arrangement with contracted providers is considered a provider incentive plan and subject to all requirements of 9.8.

9.8.4. The MCO shall submit any information regarding the incentive plans as may be required by DHH . For this proposal the MCO must submit al of the information specified in Section 9.8 and Appendix PP. The MCO shall obtain approval from DHH prior to implementation of the incentive plan.

9.8.4.1. The MCO shall receive prior DHH approval of the Physician Incentive Plan and shall submit to DHH any contract templates that involve an incentive plan for review as a material modification. The MCO shall disclose the following:

- Services that are furnished by a physician/group that are covered by any incentive plan;
- Type of incentive arrangement, *e.g.* withhold, bonus, capitation;
- Percent of withhold or bonus (if applicable);
- Panel size, and if patients are pooled, the approved method used; and
- If the physician/group is at substantial financial risk, the entity must report proof the physician/group has adequate stop loss coverage, including amount and type of stop-loss.

9.8.4.2. The MCO shall provide the information specified in 42 CFR §422.210(b) regarding its physician incentive plans to any Medicaid member upon request.

9.8.5. The proposed monetary value of these incentives and/or enhanced payments will be considered a binding contract deliverable (Appendix PP). If for some reason, including but not limited to lack of provider participation or performance,

the aggregated annual per member per month PMPM proposed is not expended the department reserves the right to require the MCO to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended.

9.8.6. Non-Payment for Specified Services

9.8.6.1. The MCO shall deny payment to providers for deliveries occurring before 39 weeks without a medical indication. MCO will use LEERS data as directed by the state to process claims for all deliveries occurring before 39 weeks.

9.8.6.2. The MCO shall deny payment to providers for Provider Preventable Conditions as defined by DHH in Section 25.8 of the Louisiana Medicaid Program Hospital Services Provider Manual.

9.9. Payment for Newborn Care

The MCO shall cover all newborn care rendered within the first month of life regardless if provided by the designated PCP or another network provider. The MCO shall compensate, at a minimum, ninety percent (90%) of the Medicaid fee-for-service rate in effect for each service coded as a primary care service rendered to a newborn member within thirty days of the member's birth regardless of whether the provider rendering the services is contracted with the MCO, but subject to the same requirements as a contracted provider.

9.10. Payment for Hospital Services

The MCO is not responsible for reimbursement of graduate medical education (GME) payments or disproportionate share hospital (DSH) payments to providers. The MCO must use the increased hospital funds received above the base rate (subject to risk adjustment) to the Full Medicaid Payment, as detailed in Appendix G – **Mercer Certification, Rate Development Methodology and Rates,** for reimbursement of inpatient and outpatient hospital services.

9.11. Payment for Ambulance Services

The MCO must use the increased ambulance services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Payment, as detailed in **Appendix G** Contract Attachment D **– Mercer Certification, Rate Development Methodology and Rates,** for reimbursement of ambulance services.

9.12. Payment for Physician Services

The MCO must use the increased physician services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Payment, as detailed in **Appendix G** Contract Attachment D**– Mercer Certification, Rate Development Methodology and Rates**, for reimbursement of physician services.

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10.0 PROVIDER SERVICES

10.1. Provider Relations

The MCO shall, at a minimum, provide a Provider Relations function to provide support and assistance to all providers in their MCO network. This function shall:

10.1.1. Be available Monday through Friday from 7 am to 7 pm Central Time to address non-emergency provider issues and on a 24/7 basis for non-routine prior authorization requests;

10.1.2. Assure each MCO provider is provided all rights outlined the **Provider's Bill of Rights** (see Appendix R);

10.1.3. Provide for arrangements to handle emergent provider issues on a 24/7 basis;

10.1.4. Provide ongoing provider training, respond to provider inquiries and provide general assistance to providers regarding program operations and requirements; ~~and~~

~~**10.1.5.**~~ Ensure regularly scheduled visits to provider sites, as well as *ad hoc* visits as circumstances dictate; and ~~.~~ provide ~~T~~technical assistance, including assistance on MCO systems and billing practices. Documentation of these visits shall be provided upon request by DHH and shall include sign-in sheets, agendas, documented follow-up action items (as appropriate), and any distributed materials.

10.1.5.

~~Technical assistance, including assistance on MCO systems and billing practices. Documentation of these visits shall be provided upon request and shall include sign-in sheets, agendas, documented follow-up action items (as appropriate), and any distributed materials.~~

10.2. Provider Toll-free Telephone Line

10.2.1. The MCO must operate a toll-free telephone line to respond to provider questions, comments and inquiries.

10.2.2. The provider access component of the toll-free telephone line must be staffed between the hours of 7am -7pm Central Time Monday through Friday to respond to provider questions in all areas, including provider complaints and regarding provider responsibilities. The provider access component must be staffed on a 24/7 basis for prior authorization requests.

10.2.3. The MCO's call center system must have the capability to track provider call management metrics. ~~.~~

10.2.4. After normal business hours, the provider service component of the toll-free telephone line must include the capability of providing information regarding normal business hours and instructions to verify enrollment for any MCO member with an emergency or urgent medical condition. This shall not be construed to mean that the provider must obtain verification before providing emergency department services and care.

~~Note that member grievances and appeals filed by providers on behalf of a member should be documented and processed in accordance with member grievance and appeals policies.~~

10.3. Provider Website

10.3.1. The MCO shall have a provider website. The provider website may be developed on a page within the MCO's existing website (such as a portal) to meet these requirements.

10.3.2. The MCO provider website shall include general and up-to-date information about the MCO as it relates to the Louisiana Medicaid program. This shall include, but is not limited to:

10.3.2.1. MCO provider manual;

10.3.2.2. MCO-relevant DHH bulletins;

10.3.2.3. Limitations on provider marketing;

10.3.2.4. Information on upcoming provider trainings;

10.3.2.5. A copy of the provider training manual;

10.3.2.6. Information on the provider complaint/dispute ~~grievance~~ system;

10.3.2.7. Information on obtaining prior authorization and referrals; ~~and~~

10.3.2.8. Information on how to contact the MCO Provider Relations; and~~.~~

10.3.2.9. General up-to-date information about all behavioral health programs and services. This shall include, but is not limited to information on requirements and reporting fraud, waste, and abuse.

10.3.2.10. The MCO shall maintain all of the above information and forms on its provider website to allow submittal of complaints and disputes electronically. In addition, the MCO shall provide providers with an address to submit grievances and appeals in writing and a phone number to submit grievances and appeals by telephone.

10.3.2.11. The MCO provider website shall provide a secure provider portal with the following capabilities:

- The MCO shall use current state and federal standards and procedures (e.g., HL7, HIPAA, CMS, CPT, ICD-10, and DSM-5) for all provider used systems and will maintain a uniform service and provider (credentials) taxonomy for billing and information management purposes.

- The MCO shall, with appropriate member consent, allow the provider access to member clinical data including assessments and Plans of Care and/or relevant data necessary to provide for appropriate coordination of care.

- The MCO is encouraged to provide online accessible methodology for providers to review and update staff rosters of credentialed and contracted providers of mental health rehabilitation services.

- The MCO shall grant user-defined DHH access to and training on the provider website.

10.3.2.12. The MCO shall provide, in accordance with national standards, claims inquiry information to providers and subcontractors via the MCO's website.

10.3.2.13. The MCO shall develop and maintain methods to communicate policies, procedures and relevant information to providers through its website, including a Provider Manual developed to disseminate all relevant information to qualified behavioral health service providers.

10.3.2.14. The MCO shall provide all qualified behavioral health service providers and subcontractors access to the DHH Service Definitions Manual and the MCO's Provider Manual, and any updates, either through the MCO's website, or by providing paper copies to providers upon request.

10.3.3. The MCO provider website is considered marketing material and, as such, must be reviewed and approved in writing within thirty (30) days of the date the MCO signs the Contract.

10.3.4. The MCO must notify DHH when the provider website is in place.

10.3.5. The MCO must remain compliant with HIPAA privacy and security requirements when providing any member eligibility or member identification information on the website.

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

10.3.7. The MCO is responsible for ensuring that the website is maintained with accurate and current information and is compliant with requirements of this RFP.

10.4. Provider Handbook

10.4.1. The MCO shall develop and issue a provider handbook within thirty (30) days of the date the MCO signs the Contract with DHH. The MCO may choose not to distribute the provider handbook via surface mail, provided it submits a written notification to all providers that explains how to obtain the provider handbook from the MCO's website. This notification shall also detail how the provider can request a hard copy from the MCO at no charge to the provider. All provider handbooks and bulletins shall be in compliance with state and federal laws. The provider handbook shall serve as a source of information regarding MCO covered services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all MCO requirements are met. At a minimum, the provider handbook shall include the following information:

10.4.1.1. Description of the MCO;

10.4.1.2. Core benefits and services the MCO must provide including a description of all behavioral health services;

10.4.1.3. Emergency service responsibilities;

10.4.1.4. Policies and procedures that cover the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the MCO to file a provider complaint the timeframes allowed for resolving claims payment issues, and the process a provider would take to escalate unresolved issues.

10.4.1.5. Information about the MCO's Grievance System, that with written permission from the member, the provider may file a grievance or appeal on behalf of the member, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers, the member's right to request continuation of services while undergoing due process in the MCO's appeal process, and any additional information specified in 42 CFR §438.10(g)(1). The member's written approval may be obtained in advance as part of the member intake process;

10.4.1.6. Medical necessity standards as defined by DHH and practice guidelines;

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

10.4.1.8. PCP responsibilities;

10.4.1.9. Other provider responsibilities under the subcontract with the MCO;

10.4.1.10. Prior authorization and referral procedures;

10.4.1.11. Standards for record keeping;
~~**10.4.1.11.** Medical records standards;~~

10.4.1.12. Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims;

10.4.1.13. MCO prompt pay requirements (see Section 9);

10.4.1.14. The MCO's chronic care management program;

10.4.1.15. Quality performance requirements; ~~and~~

10.4.1.16. Provider rights and responsibilities;~~.~~

10.4.1.17. Service authorization criteria to make medical necessity determinations;

10.4.1.18. Information on reporting suspicion of provider or member fraud, waste or abuse; and

10.4.1.19. Information on obtaining Medicaid transportation services for members.

10.4.2. The MCO shall disseminate bulletins as needed to incorporate any changes to the provider handbook.

10.4.3. The MCO shall make available to DHH for approval a provider handbook specific to the Louisiana MCO Program, no later than thirty (30) days prior to the date the MCO signs the Contract with DHH.

10.5. Provider Education and Training

10.5.1. The MCO shall provide training to all providers and their staff regarding the requirements of the Contract, including limitations on provider marketing, and identification of special needs of members. The MCO shall conduct initial training within thirty (30) days of placing a newly contracted provider, or provider group, on active status. The MCO shall also conduct ongoing training, as deemed necessary by the MCO or DHH, in order to ensure compliance with program standards and the Contract.

10.5.2. The MCO shall submit a copy of the Provider Training Manual and training schedule to DHH for approval within thirty (30) calendar days of the date the MCO signs the Contract with DHH. Any changes to the manual shall be submitted to DHH at least thirty (30) calendar days prior to the scheduled change and dissemination of such change.

10.5.3. The MCO shall develop and offer specialized initial and ongoing training in the areas including but not limited to billing procedures and service authorization requirements for network providers who have traditionally billed and obtained service authorization primarily from Medicaid and/or Medicare only. This includes but is not limited to personal care services providers and hospice providers and may include other provider types at the discretion of DHH.

10.5.4. Specialized Behavioral Health Provider Education and Training

10.5.4.1. All specialized behavioral health services training will be documented with agendas, written training materials, invited attendees, and sign-in sheets (including documentation of absent attendees). Training to be provided will include but not be limited to:

- Cultural Competency;
- Evidence-Based practices, promising practices, emerging best practices;
- Billing options and requirements and documentation requirements;
- Utilizing the Child and Adolescent Needs and Strengths (CANS) and LOCUS assessment tools;
- Integrating physical and behavioral health;
- Use of MCO systems and website; and
- Additional topics as determined through provider/member surveys and/or as directed by DHH.

10.5.4.2. The MCO shall provide prescriber education, training and outreach to support the implementation, maintenance, and updating of its behavioral health pharmacy management activities, including, but not limited to education and training relative to the Preferred Drug List, prior authorization requirements, fail first, step-therapy, approved prescribing caps, and relevant appeal, expedited appeal, and peer-to-peer procedures and protocols. The MCO shall submit its tentative prescriber training and education schedule or plan to DHH by January 1, 2016, and 7 days before any newly scheduled training event.

10.5.4.3. The MCO shall provide technical assistance and network development training (e.g., billing, behavioral health services and authorization, linguistic/cultural competency, etc.) for its behavioral health providers, including required trainings for certain behavioral health providers (e.g. Child and Adolescent Needs and Strengths (CANS), Level of Care Utilization System (LOCUS), OBH standardized training for non-licensed providers, etc.). The MCO shall maintain records of such training including completion dates trainings, which shall be made available to DHH upon request.

10.5.4.4. The MCO shall ensure that behavioral health providers are trained and/or meet training requirements in accordance with the Service Definitions Manual for the services contracted to be delivered including curriculum or equivalent standards, and DHH standard training.

10.5.4.5. The MCO shall develop, implement, and provide DHH with a copy of an annual training plan that addresses all training requirements, including involvement of members and family members in the development and delivery of trainings. The initial annual training plan including behavioral health topics shall be submitted to DHH by November 1, 2015.

~~**10.5.3.1.**~~**10.5.4.6.** The MCO shall submit a copy of any behavioral health provider training materials and a training schedule to DHH.

10.5.4.7. The MCO shall provide thirty (30) days advance notice of all trainings to DHH, and DHH shall be permitted to attend any and all provider sessions. The MCO shall maintain and provide upon DHH request all provider training reports identifying training topics provided, dates, sign-in sheets, invited/attendees' lists, and organizations trained.

~~**10.5.3.2.**~~

~~The MCO shall submit all behavioral health provider informational and training materials and presentations to DHH for approval.~~

10.6. Provider Complaint System

10.6.1. Applicable Definitions

10.6.1.1. Definition of Provider Complaint

For the purposes of this subsection, a provider complaint (also referred to as provider grievance) is any verbal or written expression, originating from a provider and delivered to any employee of the MCO, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by

the MCO, excluding request of reconsideration or appeal for specific individual claims. It does include general complaints about claim payment policies. Note that member grievances and appeals filed by providers on behalf of a member should be documented and processed in accordance with member grievance and appeals policies.

10.6.1.2. Definition of Action

For purposes of this subsection an action is defined as:

- The denial or limited authorization of a requested service, including the type or level of service; or
- The reduction, suspension, or termination of a previously authorized service; or
- The failure to provide services in a timely manner, as defined by Section 7.3 and Section 7.5 of this RFP; or
- The failure of the MCO to act within the timeframes provided in Section 10.6.5 of this RFP.

10.6.2. The MCO shall establish a Provider Complaint System with which to track the receipt and resolution of provider complaints from in-network and out-of-network providers.

10.6.3. This system must be capable of identifying and tracking complaints received by phone, in writing, or in person, on any issue that expresses dissatisfaction with a policy, procedure, or any other communication or action by the MCO.

10.6.4. As part of the Provider Complaint system, the MCO shall:

10.6.4.1. Have dedicated provider relations staff for providers to contact via telephone, electronic mail, surface mail, and in person, to ask questions, file a provider complaint and resolve problems;

10.6.4.2. Identify a key staff person specifically designated to receive and process provider complaints;

10.6.4.3. Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties and applying the MCO's written policies and procedures; and

10.6.4.4. Ensure that MCO executives with the authority to require corrective action are involved in the provider complaint escalation process, provide the names, phone numbers and e-mail address to DHH within one week of contract approval, and within 2 business days of any changes.

10.6.5. The MCO shall have and implement written policies and procedures which detail the operation of the Provider Complaint System. The MCO shall submit its Provider Complaint System policies and procedures to DHH for review and approval within thirty (30) Calendar Days of the date the Contract with DHH is

signed. Note that provider complaints must be acknowledged within business 3 days. They should be resolved as soon as feasible, but within no more than 30 calendar days unless both the provider and DHH have~~has~~ been notified of the outstanding issues, including a timeline for resolution and reason for the extension of time. All complaints should be resolved in no more than 90 days. The policies and procedures shall include, at a minimum:

10.6.5.1. Allowing providers thirty (30) days to file a written complaint and a description of how providers file complaint with the MCO and the resolution time;

10.6.5.2. A description of how and under what circumstances providers are advised that they may file a complaint with the MCO for issues that are MCO Provider Complaints and under what circumstances a provider may file a complaint directly to DHH/MMIS for those decisions that are not a unique function of the MCO;

10.6.5.3. A description of how provider relations staff are trained to distinguish between a provider complaint and an enrollee grievance or appeal in which the provider is acting on the enrollee's behalf;

10.6.5.4. A process to allow providers to consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint;

10.6.5.5. A process for thoroughly investigating each complaint and for collecting pertinent facts from all parties during the investigation;

10.6.5.6. A description of the methods used to ensure that MCO executive staff with the authority to require corrective action are involved in the complaint process, as necessary;

10.6.5.7. A process for giving providers (or their representatives) the opportunity to present their cases in person;

10.6.5.8. Identification of specific individuals who have authority to administer the provider complaint process;

10.6.5.9. A system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing; and

10.6.5.10. A provision requiring the MCO to report the status of all provider complaints and their resolution to DHH on a monthly basis in the format required by DHH.

10.6.6. The MCO shall include a description of the Provider Complaint System in the Provider Handbook and include specific instructions regarding how to contact the MCOs Provider Relations staff; and contact information for the person from the MCO who receives and processes provider complaints.

10.6.7. The MCO shall distribute the MCO's policies and procedures to in-network providers at time of subcontract and to out-of-network providers with the remittance advice (RA). The MCO may distribute a summary of these policies and procedures to providers if the summary includes information about how the provider may access the full policies and procedures on the MCO's website. This summary shall also detail how the in-network provider can request a hard copy from the MCO at no charge to the provider.

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11.0 ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

DHH contracts with an Enrollment Broker who is responsible for the Bayou Health Program's enrollment and disenrollment process for all Medicaid enrollees. The Enrollment Broker shall be the primary contact for Medicaid eligibles concerning the selection of an MCO and shall assist the potential enrollee to become a member of an MCO. The Enrollment Broker shall be the only authorized entity other than DHH, to assist a Medicaid eligible in any manner in the selection of an MCO and shall be responsible for notifying all MCO members of their enrollment and disenrollment rights and responsibilities within the timeframe specified in this Section. The Enrollment Broker's responsibilities regarding enrollment counseling can be found in Appendix W – **Enrollment Broker Responsibilities.**

The MCO shall abide by all enrollment and disenrollment procedures in this Section. Auto assignment algorithms and decisions are at the sole discretion of DHH and all proposers expressly agree to abide by those decisions.

DHH and its agent will make every effort to ensure that recipients ineligible for enrollment in the Bayou Health Program are not to be enrolled in an MCO. However, to ensure that such recipients are not enrolled in an MCO, the MCO shall assist DHH or its agent in the identification of recipients that are ineligible for enrollment in the Bayou Health Program, should such recipients become enrolled inadvertently or if their status changes from eligible to ineligible.

11.1. Maintenance of MCO for Enrollees

11.1.1. In order to minimize member disruptions, the initial contract enrollment period and annual open enrollment will be aligned with the contract start date. In subsequent years, the annual open enrollment will be in conducted in accordance with Section 11.8.

11.1.1.1. All members will be given a sixty (60) day choice period to proactively choose an MCO.

11.1.1.2. If a proactive choice of MCO is not made by the member within sixty (60) days, all members enrolled as of January 31, 2015 in an incumbent MCO (defined as an entity contracted as an CCN-P with Louisiana Medicaid as of January 31, 2015), whether through voluntary selection during the 2014 annual open enrollment period or by default if no change was requested, will be assigned automatically to that MCO on the effective date of this contract. Members of a CCN-S or CCN-P which no longer contracts with the state will be automatically enrolled using the methodology in Section 11.3.

11.1.2. All members shall be subject to the provisions in Section 11.54 below (MCO Lock-in).

11.2. Voluntary Selection of MCO for New Enrollees After February 1, 2015

11.2.1. Medicaid applicants whose financial eligibility determination is made by DHH will be provided an opportunity to choose an MCO at the time of application Upon Medicaid enrollment, this choice, if provided, will be transmitted to the Enrollment Broker.

11.2.2. All members will be provided an annual sixty day open enrollment period between November and January.

11.2.3. All Medicaid applicants will be provided an opportunity to choose an MCO at the start of a new MCO contract either through the regularly scheduled open enrollment period or special enrollment period.

11.3. Special Enrollment Period for Specialized Behavioral Health Integration

11.3.1. All populations required to mandatorily enroll into Bayou Health for Specialized Behavioral Health Services only and those Voluntary Opt-in Populations who remain in FFS Medicaid will be given a 60 day choice period to proactively choose an MCO.

11.3.2. If a proactive choice of MCO is not made by the member within sixty (60) days, DHH will automatically enroll members using the methodology in 11.4.4.

~~11.3.~~11.4. Automatic Assignment

~~11.3.1.~~**11.4.1.** DHH will auto-assign potential enrollees who do not request enrollment in a specified MCO at the time of financial application for Medicaid or through the help of the enrollment broker, or who cannot be enrolled into the requested MCO for reasons including, but not limited to, the MCO having reached its enrollment capacity limit or as a result of DHH-initiated sanctions. As specified in Section 11.8, members who fail to select a new MCO during their annual open enrollment period will remain enrolled with their existing MCO. These members will not be subject to the automatic assignment process.

~~11.3.2.~~**11.4.2.** In accordance with 42 CFR §438.50(f) the automatic assignment methodology will seek to preserve existing provider-recipient relationships and relationships with providers that have traditionally served Medicaid recipients. After consideration of provider-recipient relationships, the methodology will assign recipients equitably among MCOs, excluding those subject to an intermediate sanction.

~~11.3.3.~~**11.4.3.** The automatic assignment methodology for Mandatory Populations for all covered services shall be based on the following hierarchy:

~~11.3.3.1.~~**11.4.3.1.** If the member has immediate family or household members enrolled in an MCO the member will be enrolled in that MCO.

~~11.3.3.2.~~**11.4.3.2.** If MCO assignment cannot be made based on the member's family or household enrollment, the Enrollment Broker will determine the member's most current previous relationship with an MCO (including previous enrollment in a CCN-S plan). If a previous MCO relationship is identified and the member's PCP is in-network, the member will be enrolled with the previous MCO.

~~11.3.3.3.~~**11.4.3.3.** If there is no previous MCO relationship, or the member's PCP is not currently in-network, the Enrollment Broker shall use a round robin method to determine the MCO assignment that maximizes the preservation of existing provider-recipient relationships.

~~11.3.3.4.~~11.4.3.4. If an MCO's membership is comprised of forty percent (40%) or more of total statewide membership at the end of any quarter, that plan will be removed from the auto assignment round robin process for the following quarter but members can continue to pro-actively select that plan.

~~11.3.3.5.~~11.4.3.5. In addition, the MCO's quality measures may be factored into the algorithm for automatic assignment, at the discretion of DHH.

11.4.4. The auto assignment methodology for Mandatory Populations for Specialized Behavioral Health services only and for Voluntary Opt-in populations shall be based on the following hierarchy:

11.4.4.1. If the member has immediate family or household members enrolled in an MCO, the member will be enrolled in that MCO.

11.4.4.2. If MCO assignment cannot be made based on the member's family or household enrollment, the Enrollment Broker shall use a round robin method to determine the MCO assignment that maximizes the preservation of existing Specialized Behavioral Health provider-recipient relationships.

~~11.4.~~11.5. MCO Lock-In Period

~~11.4.1.~~11.5.1. The MCO members shall be enrolled for a period of twelve (12) months or until their next open enrollment period. MCO members~~Mandatory eligibles~~ will be given ninety (90) days from the effective date of the Initial Enrollment in which they may change MCOs for any reason. After the initial ninety (90) day period, Medicaid enrollees/members shall be locked into an MCO for twelve (12) months from the effective date of enrollment or until the next annual open enrollment period, unless disenrolled for cause, contingent upon their continued Medicaid eligibility.

~~11.5.~~11.6. Voluntary Opt In~~Out~~ Enrollees

~~**11.5.1.** Voluntary enrollees will be given a ninety (90) day choice period to change MCO or opt out of the Bayou Health program.~~

~~The~~ ~~Enrollment Broker will ensure that all voluntary populations will be notified at the time of enrollment of their ability to opt out without cause during the first ninety (90) days.~~

~~**11.5.2.** Voluntary enrollees who do not opt out within the specified time frame will be locked in to the MCO for twelve (12) months or until the next open enrollment period unless they show cause for disenrollment from the MCO, Contingent upon their continued Medicaid eligibility.~~

~~11.6. Voluntary Opt In Enrollees~~

11.6.1. Voluntary opt in enrollees will be allowed to request participation in the Bayou Health program for physical health services at any time. The effective date of enrollment shall be effective no later than the first day of the second month following the calendar month the request for enrollment is received. ~~-~~Voluntary opt in enrollees will not be enrolled with a retroactive begin date for their physical health services.

11.6.2. The Enrollment Broker will ensure that all voluntary opt-in populations are notified at the time of enrollment of their ability to opt out of the Bayou Health program for their physical health services without cause at any time. The effective date of disenrollment shall be the first day of a month and no later than the first day of the second month following the calendar month the request for disenrollment is received.

11.6.3. Following their opt into the Bayou Health program for their physical health services and selection of an MCO and subsequent ninety (90) day choice period, during which they can change MCO for any reason, these members will be locked in to the MCO for twelve (12) months from the effective date of enrollment or until the next annual open enrollment, unless they opt out of the Bayou Health program for their physical health services.

11.7. Assistance with Medicaid Eligibility Renewal

Renewals of Medicaid and CHIP eligibility are conducted annually. The MCO shall assist with Medicaid eligibility renewal efforts with their members. DHH will provide the MCO with a list of members up for renewal no less than 60 days prior to a member's renewal date. The list will be a subset of the entire renewal population, as determined by DHH. Assistance should include, but is not limited to, education and outreach to members detailing how a member can renew their Medicaid eligibility, through letters, text messages, e-mails and outbound calls. All materials should comply with the requirements set forth in Section 12 of the RFP.

11.8. Annual Open Enrollment

11.8.1. DHH, through its Enrollment Broker, will provide an opportunity for all MCO members to retain or select a new MCO during a single statewide annual open enrollment period. Prior to the annual open enrollment period, the Enrollment Broker will mail a re-enrollment offer to the MCO member to determine if they wish to continue to be enrolled with their current MCO.

11.8.2. Each MCO member shall receive information and the offer of assistance with making informed choices about the participating MCOs and the availability of choice counseling. The Enrollment Broker shall provide the individual with information on the MCOs from which they may select. Each Medicaid enrollee shall be given sixty (60) calendar days to retain their existing MCO or select a new MCO.

11.8.3. Unless the member becomes ineligible for the Bayou Health Program ~~or provides written, oral or electronic notification that they are a voluntary opt out member or voluntary opt in member and no longer wish to be enrolled in the MCO~~, members that fail to select a new MCO during their annual open enrollment period will remain enrolled with the existing MCO.

11.9. Suspension of and/or Limits on Enrollments

11.9.1. The MCO shall identify the maximum number of MCO members it is able to enroll and maintain under the Contract prior to initial enrollment of Medicaid eligibles. The MCO shall accept Medicaid enrollees as MCO members in the order in which they are submitted by the Enrollment Broker without restriction [42 CFR

§438.6(d)(1)] as specified by DHH up to the limits specified in the Contract. The MCO shall provide services to MCO members up to the maximum enrollment limits specified in the Contract. DHH reserves the right to approve or deny the maximum number of MCO members to be enrolled in the MCO based on DHH's determination of the adequacy of MCO capacity.

11.9.2. Consistent with reporting requirements in Section 18.0 of this RFP, the MCO shall submit a quarterly update of the maximum members. The MCO shall track slot availability and notify DHH's Enrollment Broker when filled slots are within ninety percent (90%) of capacity. The MCO is responsible for maintaining a record of total PCP linkages of Medicaid members and provide this information quarterly to DHH.

11.9.3. DHH will notify the MCO when the MCO's enrollment levels reach ninety-five percent (95%) of capacity and will not automatically assign Medicaid eligibles.

11.9.4. In the event the MCO's enrollment reaches forty percent (40%) of the total enrollment in the state, the MCO will not receive additional members through the automatic assignment algorithm. However, the MCO may receive new members as a result of: member choice and newborn enrollments; reassignments when a member loses and regains eligibility selection when other family or case members are members of the MCO; need to ensure continuity of care for the member; or determination of just cause by DHH. DHH's evaluation of an MCO's enrollment market share will take place on a calendar quarter.

11.10. MCO Enrollment Procedures

11.10.1. Acceptance of All Eligibles

11.10.1.1. The MCO shall enroll any mandatory or voluntary MCO eligible who selects it or is assigned to it regardless of the individual's age, sex, ethnicity, language needs, or health status. The only exception will be if the MCO has reached its enrollment capacity limit.

11.10.1.2. The MCO shall accept potential enrollees in the order in which they are assigned without restriction, up to the enrollment capacity limits set under the Contract with DHH.

11.10.1.3. The MCO shall not discriminate against MCO members on the basis of their health history, health status, need for health care services or adverse change in health status; or on the basis of age, religious belief, sex/gender, or sexual orientation. This applies to enrollment, re-enrollment or disenrollment from the MCO. The MCO shall be subject to monetary penalties and other sanctions if it is determined by DHH that the MCO has requested disenrollment for any of these reasons.

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

11.10.2. Effective Date of Enrollment

The effective date of initial enrollment in an MCO shall be the date provided on the outbound ANSI ASC X12 834 Benefit Enrollment & Maintenance electronic transaction initiated by the Enrollment Broker.

A member's effective date of enrollment in an MCO will be the member's effective date of eligibility for Medicaid, subject to the following limitation.

Individuals may be retroactively eligible for Medicaid. Individuals retroactively eligible for Medicaid may be retroactively enrolled in an MCO. However, retroactive enrollment in an MCO is limited to 12 months.

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

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

DHH shall make monthly capitation payments to the MCO from the effective date of an enrollee's MCO enrollment. Claims for dates of service prior to the effective date of MCO enrollment shall be submitted by providers directly to the Medicaid Fiscal Intermediary for payment.

Except for applicable Medicaid cost sharing, the MCO shall ensure that members are held harmless for the cost of covered services provided as of the effective date of enrollment with the MCO.

11.10.3. Change in Status

11.10.3.1. The MCO shall report to DHH's Medicaid Customer Service Unit any changes in contact information or living arrangements for families or individual members within five (5) business days of identification, including changes in mailing address, residential address if outside Louisiana, e-mail address, telephone number, the manner and format determined by DHH.

11.10.3.2. The MCO shall submit an MCO Initiated Request for Disenrollment to DHH through to the Enrollment Broker for other known changes in status of eligibility for participation in Bayou Health including but not limited to death, admission to intermediate care facility for people with developmental disabilities for members age 21 and overnursing facility, and entry into involuntary custody/incarceration.

11.10.4. Newborn Enrollment

11.10.4.1. The MCO shall contact members who are expectant mothers sixty (60) calendar days prior to the expected date of delivery to encourage the mothers to choose a PCP for their newborns. In the event that the pregnant member does not select a PCP, the MCO shall provide the member with a minimum of fourteen (14) days after birth to select a PCP prior to assigning one.

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

A newborn may be inadvertently enrolled in an MCO different than its mother. When such cases are identified, DHH shall immediately:

- Disenroll the newborn from the incorrect MCO
- Enroll the newborn in the same MCO as its mother with the same effective date as when the newborn was enrolled in the incorrect MCO
- Recoup any payments made to the incorrect MCO for the newborn; and
- Make payments only to the correct MCO for the period of coverage.

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

11.10.4.2. The MCO shall be responsible for assuring that hospital subcontractors report the births of newborns within twenty-four (24) hours of birth for enrolled members using DHH's web-based Facility Notification System (FNS) Newborn Manual (See Appendix S). If the member makes a PCP selection during the hospital stay and one was not already identified, this information shall be reported to the plan. If no selection is made, the MCO shall provide the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one. Enrollment of newborns who are Louisiana residents at the time of birth and who are not surrendered prior to hospital discharge shall be retroactive to the date of the birth.

11.10.4.3. The MCO shall require its hospital providers to register all births through LEERS (Louisiana Electronic Event Registration System) administered by DHH/Vital Records Registry.

11.10.4.4. LEERS information and training materials at the following url: http://new.dhh.louisiana.gov/index.cfm/page/669

11.11. Disenrollment

11.11.1. Disenrollment is any action taken by DHH or its designee to remove a Medicaid MCO member from the MCO following the receipt and approval of a written request for disenrollment or a determination made by DHH or its designee that the member is no longer eligible for Medicaid or the Bayou Health Program.

11.11.2. The Enrollment Broker shall be the single point of contact to the MCO member for notification of disenrollment.

11.11.3. Member Initiated Disenrollment – a member may request disenrollment from an MCO as follows:

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

- The MCO does not, because of moral or religious objections, cover the service the member seeks;
- The member requests to be assigned to the same MCO as family members;
- The member needs related services to be performed at the same time, not all related services are available within the MCO and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk;
- The contract between the MCO and DHH is terminated;
- Poor quality of care;
- Lack of access to MCO core benefits and services covered under the contract;
- Documented lack of access within the MCO to providers experienced in dealing with the member's healthcare needs;
- The member's active specialized behavioral health provider ceases to contract with the MCO;
- Member moves out of the MCO's service area, i.e. out of state; or
- Any other reason deemed to be valid by DHH and/or its agent.

11.11.3.2. Without cause for the following reasons:

- During the ninety (90) day opt-out period following initial enrollment with the MCO for voluntary members;
- During the ninety (90) days following the postmark date of the member's notification of enrollment with the MCO;

  Once a year thereafter during the member's annual open enrollment period;
- Upon automatic re-enrollment under 42 CFR §438.56(g), if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or
- If DHH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a) (3).

11.11.3.3. The member (or his/ her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.

11.11.3.4. If the member's request for disenrollment is denied by the Enrollment Broker, the member can appeal directly to the State Fair Hearing process.

11.11.4. MCO Initiated Disenrollment

11.11.4.1. The MCO shall not request disenrollment because of a member's health diagnosis, adverse change in health status, utilization of medical services, diminished medical capacity, pre-existing medical condition, refusal of medical care or diagnostic testing, uncooperative or disruptive behavior resulting from him or her special needs, unless it seriously impairs the MCO's ability to furnish services to either this particular member or other MCO members, the member attempts to exercise his/her rights under the MCO's grievance system, or attempts to exercise her/her right to change, for cause, the primary care provider that he/she has chosen or been assigned. (42 CFR §438.56(b)(2)).

11.11.4.2. The MCO shall not request disenrollment for reasons other than those stated in this RFP. (See Appendix U – **Guidelines for Involuntary Member Disenrollment**). In accordance with 42 CFR §438.56(b)(3), DHH will ensure that the MCO is not requesting disenrollment for other reasons by reviewing the mandatory MCO Disenrollment Request Forms submitted to the Enrollment Broker.~~.~~

11.11.4.3. The following is the only~~are~~ allowable reason~~s~~ for which the MCO may request involuntary disenrollment of a member:

- ~~The~~ The member misuses or loans the member's MCO-issued ID card to another person to obtain services. In such case the MCO shall report the event to DHH.~~ or~~

- ~~The member's behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the MCO seriously impairs the organization's ability to furnish services to either the member or other members.~~

~~The MCO shall~~ .~~take reasonable measures to correct member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.~~

11.11.4.4. When the MCO ~~requests an involuntary disenrollment, it shall notify the member in writing that the MCO is requesting disenrollment, the reason for the request, and an explanation that the MCO is requesting that the member be disenrolled in the month following member notification~~request for involuntary disenrollment is approved by the Department, the MCO shall notify the member in writing of the requested disenrollment, the reason for the request, and the effective date.

~~.~~

11.11.4.5. The MCO shall submit disenrollment requests to the Enrollment Broker which should include, at a minimum the member's name, ID number, detailed reasons for requesting the disenrollment, and a description of the measures taken to correct member behavior prior to requesting disenrollment, utilizing

the **MCO Initiated Request for Member Disenrollment** form (See Appendix T).

11.11.4.6. The MCO shall not submit a disenrollment request at such a date as would cause the disenrollment to be effective earlier than forty-five (45) calendar days after the occurrence of the event prompting the request for involuntary disenrollment. The MCO shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.

11.11.4.7. All requests will be reviewed on a case-by-case basis and are subject to the sole discretion of DHH or its designee (Enrollment Broker). All decisions are final and not subject to the dispute resolution process by the MCO.

11.11.4.8. The Enrollment Broker will provide written notice of disenrollment to the member and request that the member choose a new MCO. The notice shall include a statement that if the member disagrees with the decision to disenroll the member from the MCO, the member has a right to file an appeal directly through the State Fair Hearing process.

11.11.4.9. Until the member is disenrolled by the Enrollment Broker, the MCO shall continue to be responsible for the provision of all core benefits and services to the member.

11.11.5. Disenrollment Effective Date

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

11.11.5.2. If DHH or its designee fails to make a disenrollment determination by the first (1st) day of the second (2nd) month following the month in which the request for disenrollment is filed, the disenrollment is considered approved.

11.11.5.3. DHH, the MCO, and the Enrollment Broker shall reconcile enrollment/disenrollment issues at the end of each month utilizing an agreed upon procedure.

11.11.6. DHH Initiated Disenrollment and Changes

DHH will notify the MCO of the member's disenrollment or change in enrollment status due to the following reasons:

11.11.6.1. Loss of Medicaid eligibility or loss of MCO enrollment eligibility;

11.11.6.2. Death of a member;

11.11.6.3. Member's intentional submission of fraudulent information;

11.11.6.4. Member becomes an inmate in a public institution;

11.11.6.5. Member moves out-of-state;

11.11.6.6. Member becomes Medicare eligible;

11.11.6.7. Member is placed in a long term care facility (nursing facility or intermediate care facility for persons with developmental disabilities);

11.11.6.8. To implement the decision of a hearing officer in an appeal proceeding by the member against the MCO or as ordered by a court of law.

11.12. Enrollment and Disenrollment Updates

11.12.1. DHH's Enrollment Broker will notify each MCO at specified times each month of the Medicaid eligibles that are enrolled, re-enrolled, or disenrolled from their MCO for the following month. The MCO will receive this notification through the ASC X12N 834 Benefit Enrollment and Maintenance electronic transaction.

11.12.2. DHH will use its best efforts to ensure that the MCO receives timely and accurate enrollment and disenrollment information. In the event of discrepancies or irresolvable differences between DHH and the MCO regarding enrollment, disenrollment and/or termination, DHH's decision is final.

11.13. Daily Updates

The Enrollment Broker shall make available to the MCO daily via electronic media, (ASC X12N 834 Benefit Enrollment and Maintenance transaction) updates on members newly enrolled into the MCO in the format specified in the ***MCO Systems Companion Guide***. The MCO shall have written policies and procedures for receiving these updates, incorporating them into its management information system and ensuring this information is available to their providers. Policies and procedures shall be available for review at the pre-implementation Readiness Review.

11.14. Weekly Reconciliation

11.14.1. Enrollment

The MCO is responsible for weekly reconciliation of the membership list of new enrollments and disenrollments received from the Enrollment Broker against its internal records. The MCO shall provide written notification to the Enrollment Broker of any data inconsistencies within 10 calendar days of receipt of the data file.

11.14.2. Payment

The MCO will receive monthly electronic file (ASC X12N 820 Transaction) from the Medicaid Fiscal Intermediary (FI) listing all members for whom the MCO received a capitation payment and the amount received. The MCO is responsible for reconciling this listing against its internal records. It is the MCO's responsibility to notify the FI of any discrepancies within three (3) months of the file date. Lack of compliance with reconciliation requirements will result in the withholding of portion of future monthly payments and/or monetary penalties as defined Section 20.0 of this RFP until requirements are met.

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12.0 MARKETING AND MEMBER EDUCATION

12.1. General Guidelines

12.1.1. Marketing, for purposes of this RFP, is defined in 42 CFR §438.104 (a) as any communication from an MCO to a Medicaid eligible who is not enrolled in that MCO that can reasonably be interpreted to influence the Medicaid eligible to 1) enroll in that particular MCO's Medicaid product, or 2) either not enroll in, or disenroll from, another MCO's Medicaid product.

12.1.2. Marketing differs from member education, which is defined as communication with an **enrolled** member of an MCO for the purpose of retaining the member as an enrollee, and improving the health status of enrolled members.

12.1.3. Marketing and member education include both verbal presentations and written materials.

12.1.4. Marketing materials generally include, but are not limited to, the concepts of advertising, public service announcements, printed publications, websites, social media, mobile device applications, broadcasts and electronic messages designed to increase awareness and interest in the MCO. This includes any information that references the MCO, is intended for general distribution, and is produced in a variety of print, broadcast or direct marketing media.

12.1.5. Member materials generally include, but are not limited to, member handbooks, identification cards, provider directories, health education materials, form letters, mass mailings, e-mails and member letters, and newsletters.

12.1.6. All marketing and member education guidelines are applicable to the MCO, its agents, subcontractors, volunteers, and/or providers.

12.1.7. All marketing and member education activities shall be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of beneficiaries or the general community.

12.1.8. All marketing and member materials and activities shall comply with the requirements in 42 CFR §438.10 and the DHH requirements set forth in this RFP.

12.1.9. The MCO is responsible for creation, production and distribution of its own marketing and member materials to its enrollees. DHH and the DHH Enrollment Broker will only be responsible for distributing general material developed and produced by the MCO for inclusion in the enrollment package distributed to Medicaid enrollees. DHH will determine which materials will be included in the Enrollment Broker generated packet and which materials will be distributed by the MCO.

12.1.10. Under the Bayou Health Program, all direct marketing to eligibles or potential eligibles will be performed by DHH or its designee in accordance with 42 U.S.C. §1396u-2(d)(2)(A) and 42 CFR §438.104.

12.1.11. Activities involving distribution and completion of an MCO enrollment form during the course of enrollment activities is an enrollment function and is the sole responsibility of DHH's Enrollment Broker.

12.1.12. The MCO shall assure DHH that marketing and member materials are accurate and do not mislead, confuse, or defraud the enrollee/potential enrollee or DHH as specified in 42 U.S.C. §1396u-2(d)(2) and 42 CFR §438.104.

12.1.13. The MCO shall comply with the Office of Minority Health, Department of Health and Human Services' "Cultural and Linguistically Appropriate Services Guidelines" at the following url: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 and participate in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees.

12.1.14. The MCO shall develop marketing and member materials that address members as per the MCO populations outlined in Section 3.3.3 of the Contract (i.e., those who receive the full range of benefits as outlined in this contract versus members covered only for specialized behavioral health and NEMT services).

12.2. Marketing and Member Education Plan

12.2.1. The MCO shall develop and implement a plan detailing the marketing and member education activities it will undertake and materials it will create during the contract period, incorporating DHH's requirements for participation in the MCO Program. The detailed plan must be submitted to DHH for review and approval within thirty (30) calendar days from the date the Contract is signed.

12.2.2. The MCO shall not begin member education activities associated with this contract prior to the approval of the marketing and member education plan.

12.2.3. The MCOs' plan shall take into consideration projected enrollment levels for equitable coverage of the entire MCO service area. The plan should clearly distinguish between **marketing** activities and materials and **member education** activities and materials. The plan shall include, but is not limited to:

12.2.3.1. Stated marketing and member education goals and strategies;

12.2.3.2. A marketing and member education calendar, which begins with the date of the signed contract, between DHH and the MCO, and runs through the first calendar year of providing services to Medicaid enrollees, that addresses all marketing areas: advertising plans, coverage areas, Web site development and launch plans, printed materials, material distribution plans (including specific locations), outreach activities (health fairs, area events, etc.);

12.2.3.3. A summary of value added benefits to be used in the creation of a plan comparison chart to assist potential enrollees in selecting the MCO that best meets their needs;

12.2.3.4. Distribution methods and schedules for all materials, including media schedules for electronic or print advertising (include date and station or publication);

12.2.3.5. The MCO's plans for new member outreach, including welcome packets and welcome call;

12.2.3.6. The MCO's plan to incorporate patient engagement tools such as smartphone-based support programs, mobile applications or text messaging innovations. A smartphone-based support program could include the following features:

12.2.3.6.1. Native mobile applications and / or mobile-friendly content that is accessible across a broad range of smartphones;

12.2.3.6.2. Consumer-friendly, engaging content that helps keep patients on-track with key health appointments and screenings;

12.2.3.6.3. Tools to help stratify users by risk profile and direct the higher risk users to State-based or plan-based resources;

12.2.3.6.4. Outreach support to educate patients about the mobile tools; and

12.2.3.6.5. Reporting and analytics to help the State measure the effectiveness of the smartphone-based support program.

12.2.3.7. How the MCO plans intends to meet the informational needs, relative to marketing (for prospective enrollees) and member education (for current enrollees), for the physical and cultural diversity of the service area. This may include, but is not limited to: a description of provisions for non-English speaking prospective enrollees, interpreter services, alternate communication mechanisms (such as sign language, Braille, audio tapes);

12.2.3.8. A list of all subcontractors engaged in marketing or member education activities for the MCO;

12.2.3.9. A copy of the MCO training curriculum for marketing representatives (both internal and subcontractor);

12.2.3.10. The MCO's procedure for monitoring and enforcing compliance with all marketing and member education guidelines, in particular the monitoring of prohibited marketing methods, among internal staff and subcontractors;

12.2.3.11. Copies of all marketing and member materials (print and multimedia) planned for distribution by the MCO or any of its subcontractors that are directed at Medicaid eligibles or potential eligibles.

12.2.3.12. Copies of marketing and member materials that are 1) currently in concept form, but not yet produced (should include a detailed description) or 2) samples from other states that will be duplicated in a similar manner for the Louisiana Bayou Health population.

12.2.3.13. Details of proposed marketing and member education activities and events. All activities must be submitted in the plan using the approved format, **Event Submission Calendar**;

12.2.3.14. Details regarding the basis it uses for awarding bonuses or increasing the salary of marketing representatives and employees involved in marketing;

12.2.3.15. Details for supplying current materials to service regions as well as plans to remove outdated materials in public areas; and

12.2.3.16. The MCO's protocol for responding to unsolicited direct contact (verbal or written) from a potential member (the MCO is not allowed to engage in marketing encounters with potential members, but Medicaid enrollees may seek out specific MCOs for information).This should include:

- Circumstances that will initiate referral to the Enrollment Broker;
- Circumstances that will initiate referral to the Medicaid Customer Service Line (toll free #1-888-342-6207);
- Circumstances that will terminate the encounter; and
- Circumstances that will prompt the MCO to distribute materials to the potential member and a draft of those materials (which must refer all enrollment inquiries to the Enrollment Broker).

12.2.3.17. Any changes to the marketing and member education plan or included materials or activities must be submitted to DHH for approval at least thirty (30) days before implementation of the marketing or member education activity, unless the MCO can demonstrate just cause for an abbreviated timeframe.

12.3. Prohibited Marketing Activities

The MCO and its subcontractors are prohibited from in engaging in the following activities:

12.3.1. Marketing directly to Medicaid potential enrollees or MCO prospective enrollees, including persons currently enrolled in Medicaid or other MCOs (including direct mail advertising, "spam", door-to-door, telephonic, or other "cold call" marketing techniques);

12.3.2. Asserting that the MCO is endorsed by CMS, the federal or state government or similar entity;

12.3.3. Distributing plans and materials or making any statement (written or verbal) that DHH determines to be inaccurate, false, confusing, misleading or intended to defraud members or DHH. This includes statements which mislead or falsely describe covered services, membership or availability of providers and qualifications and skills of providers and assertions the recipient of the communication must enroll in a specific plan in order to obtain or not lose benefits;

12.3.4. Portraying competitors or potential competitors in a negative manner;

12.3.5. Attaching a Medicaid application and/or enrollment form to marketing materials to any member not currently enrolled with the MCO ;

12.3.6. Assisting with enrollment or improperly influencing MCO selection;

12.3.7. Inducing or accepting a member's enrollment or disenrollment to any member not currently enrolled with the MCO

12.3.8. Using the seal of the state of Louisiana, DHH's name, logo or other identifying marks on any materials produced or issued, without the prior written consent of DHH;

12.3.9. Distributing marketing information (written or verbal) that implies that joining MCOs or a particular MCO is the only means of preserving Medicaid coverage or that MCOs or a particular MCO is the only provider of Medicaid services and the potential enrollee must enroll in the MCO or MCOs to obtain benefits or not lose benefits;

12.3.10. Comparing their MCO to another organization/ MCO by name;

12.3.11. Sponsoring or attending any marketing or community health activities or events without notifying DHH within the timeframes specified in this RFP;

12.3.12. Engaging in any marketing activities, including unsolicited personal contact with a potential enrollee, at an employer-sponsored enrollment event where employee participation is mandated by the employer;

12.3.13. Marketing or distributing marketing materials, including member handbooks, and soliciting members in any other manner, inside, at the entrance or within 100 feet of check cashing establishments, public assistance offices, /DCFS eligibility offices for the Supplemental Nutrition Assistance Program (SNAP), FITAP, Health Units, Medicaid Eligibility Offices, and/or certified Medicaid Application Centers without prior approval from DHH. Medicaid Eligibility Office staff or approved DHH agents shall be the only authorized personnel to distribute such materials;

12.3.14. Conducting marketing or distributing marketing materials in hospital EDs, including the ED waiting areas, patient rooms or treatment areas;

12.3.15. Copyrighting or releasing any report, graph, chart, picture, or other document produced in whole or in part relating to services provided under this Contract on behalf of the MCO without the prior written consent of DHH;

12.3.16. Purchasing or otherwise acquiring or using mailing lists of Medicaid eligibles from third party vendors, including providers and state offices;

12.3.17. Using raffle tickets or event attendance or sign-in sheets to develop mailing lists of prospective enrollees;

12.3.18. Charging members for goods or services distributed at events;

12.3.19. Charging members a fee for accessing the MCO Web site;

12.3.20. Influencing enrollment in conjunction with the sale or offering of any private insurance or Medicare Advantage Plan;

12.3.21. Using terms that would influence, mislead or cause potential members to contact the MCO, rather than the DHH-designated Enrollment Broker, for enrollment;

12.3.22. Referencing the commercial or Medicare Advantage Plan component of the MCO in any of its Medicaid MCO enrollee marketing materials, if applicable;

12.3.23. Using terms in marketing materials such as “choose,” “pick,” “join,” etc. unless the marketing materials include the Enrollment Broker’s contact information;

12.4. Allowable Marketing Activities

12.4.1. The MCO and its subcontractors shall be permitted to perform the following activities:

12.4.1.1. Distribute general information through mass media (i.e. newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, billboards and other media outlets) in keeping with prohibitions to placement as detailed in this RFP;

12.4.1.2. Make telephone calls and home visits only to members currently enrolled in the MCO (member education and outreach) for the purpose of educating them about services offered by or available through the MCO;

12.4.1.3. Respond to verbal or written requests for information made by potential members, in keeping with the response plan outlined in the marketing plan approved by DHH prior to response;

12.4.1.4. Provide promotional giveaways that exceed the $15.00 value to current members only;

12.4.1.5. Attend or organize activities that benefit the entire community such as health fairs or other health education and promotion activities. Notification to DHH must be made of the activity and details must be provided about the planned marketing activities using the **Event Submission Calendar**;

12.4.1.6. Attend activities at a business at the invitation of the entity. Notification to DHH must be made of the activity and details must be provided about the planned marketing activities using the **Event Submission Calendar**;

12.4.1.7. Conduct telephone marketing only during incoming calls from potential members. The MCO may return telephone calls to potential members only when requested to do so by the caller. The MCO must utilize the response plan outline in the marketing plan, approved by DHH, during these calls; and

12.4.1.8. Send plan-specific materials to potential members at the potential member’s request.

12.4.2. In any instance where an MCO-allowable activity conflicts with a prohibited activity, the prohibited activity guidance shall be followed.

12.5. Marketing and Member Materials Approval Process

12.5.1. The MCO must obtain prior written approval from DHH for all marketing and member materials for potential or current enrollees. This includes, but is not limited to, print, television, web, and radio advertisements; member handbooks,

identification cards and provider directories; call scripts for outbound calls or customer service centers; MCO website screen shots; promotional items; brochures; letters and mass mailings and e-mailings. Neither the MCO nor its subcontractors may distribute any MCO marketing or member materials without DHH consent.

12.5.2. All proposed materials must be submitted via email to DHH. Materials must be submitted in PDF format unless an alternative format is approved or requested by DHH.

12.5.2.1. Materials submitted as part of the original marketing and member education plan will be considered approved with the approval of the plan if the materials were in final draft form.

12.5.3. MCOs must obtain prior written approval for all materials developed by a recognized entity having no association with the MCO, including but not limited to, those developed by a government entity or a nonprofit organization, that the MCO wishes to distribute. DHH will only consider materials when submitted by the MCO (not subcontractors).

12.5.4. Review Process for Materials

12.5.4.1. DHH will review the submitted marketing and member materials and either approve, deny or submit changes within thirty (30) calendar days from the date of submission;

12.5.4.2. Once member materials are approved in writing by DHH, the MCO shall submit an electronic version (PDF) of the final printed product, unless otherwise specified by DHH, within ten (10) calendar days from the print date. If DHH requests that original prints be submitted in hard copy, photo copies may not be submitted for the final product. Upon request, the MCO must provide additional original prints of the final product to DHH;

12.5.4.3. Prior to modifying any approved member material, the MCO shall submit for written approval by DHH, a detailed description of the proposed modification accompanied by a draft of the proposed modification;

12.5.4.4. DHH reserves the right to require the MCO to discontinue or modify any marketing or member materials after approval;

12.5.4.5. MCO materials used for the purpose of marketing and member education, except for the original MCO marketing and member education plan, are deemed approved if a response from DHH is not returned within thirty (30) calendar days following receipt of materials by DHH; and

12.5.4.6. The MCO must review all marketing and member materials on an annual basis and revise materials, if necessary, to reflect current practices. Any revisions must be approved by DHH prior to distribution.

12.6. Events and Activities Approval Process

12.6.1. The MCO must provide written notice to DHH for all marketing and member education events and activities for potential or current enrollees as well as any

community/health education activities that are focused on health care benefits (health fairs or other health education and promotion activities). Notice to DHH may be made prior to the event, or in the form of the Marketing Plan Monthly Report (Appendix BB).

12.6.2. The MCO must obtain prior written approval from DHH for any activities that include sponsorships.

12.6.3. The MCO must obtain prior written approval from DHH for any press or media events or activities.

12.6.4. All proposed events and activities, including proposed sponsorships, must be submitted to DHH using the **Event Submission Calendar**. (See Appendix X)

12.6.4.1. Activities and events submitted as part of the original marketing and member education plan will be considered approved with the approval of the plan if the activity or event details are complete.

12.6.5. Review Process for Events and Activities

12.6.5.1. DHH will review proposed sponsorship, press or media events and activities and either approve or deny within fourteen (14) business days from the date of submission.

12.6.5.2. In the case where a sponsorship, press, or media event or activity arises and approval within the seven (7) business day timeframe is not possible due to the proximity of the event or activity, the MCO may request an expedited approval. DHH reserves the right to deny such requests.

12.6.5.3. DHH reserves the right to require the MCO to discontinue or modify any marketing or member education events after approval.

12.6.5.4. Proposed sponsorships, press or media events and activities, except for those included in the original MCO marketing and member education plan, are deemed approved if a response from DHH is not returned within seven (7) business days following notice of event to DHH.

12.6.5.5. Any revisions to approved sponsorships, press or media events and activities must be resubmitted for approved by DHH prior to the event or activity using the **Event Submission Calendar**.

12.7. MCO Provider Marketing Guidelines

12.7.1. When conducting any form of marketing in a provider's office, the MCO must acquire and keep on file the written consent of the provider.

12.7.2. The MCO may not require its providers to distribute MCO-prepared marketing communications to their patients.

12.7.3. The MCO may not provide incentives or giveaways to providers to distribute them to MCO members or potential MCO members.

12.7.4. The MCO may not conduct member education or distribute member education materials in provider offices.

12.7.5. The MCO may not allow providers to solicit enrollment or disenrollment in an MCO, or distribute MCO-specific materials at a marketing activity.

12.7.6. The MCO may not provide printed materials with instructions detailing how to change MCOs to members of other MCOs to providers.

12.7.7. The MCO shall instruct participating providers regarding the following communication requirements:

12.7.7.1. Participating providers who wish to let their patients know of their affiliations with one or more MCOs must list each MCO with whom they have contracts;

12.7.7.2. Participating providers may display and/or distribute health education materials for **all** contracted MCOs or they may choose not to display and/or distribute for **any** contracted MCOs. Health education materials must adhere to the following guidance:

- Health education posters cannot be larger than 16” X 24”;
- Children’s books, donated by MCOs, must be in common areas;
- Materials may include the MCOs name, logo, phone number and Web site; and
- Providers are not required to distribute and/or display all health education materials provided by each MCO with whom they contract. Providers can choose which items to display as long as they distribute items from each contracted MCO and that the distribution and quantity of items displayed are equitable.

12.7.7.3. Providers may display marketing materials for MCOs provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all MCOs with whom the provider has a contract.

12.7.7.4. Providers may display MCO participation stickers, but they must display stickers by **all** contracted MCOs or choose to not display stickers for **any** contracted MCOs.

12.7.7.5. MCO stickers indicating the provider participates with a particular MCO cannot be larger than 5" x 7” and not indicate anything more than “the MCO or MCO is accepted or welcomed here.”

12.7.7.6. Providers may inform their patients of the benefits, services and specialty care services offered through the MCOs in which they participate. However, providers may not recommend one MCO over another MCO, offer patients incentives for selecting one MCO over another, or assist the patient in deciding to select a specific MCO in any way, including but not limited to faxing, using the office phone, or a computer in the office.

12.7.7.7. Upon actual termination of a contract with the MCO, a provider that has contracts with other MCOs may notify their patients of the change in status and the impact of such a change on the patient included the date of the contract termination. Providers must continue to see current patients enrolled in the MCO until the contract is terminated according to all terms and conditions specified in the contract between the provider and the MCO.

12.7.7.8. MCOs shall not produce branded materials instructing members on how to change a MCO. They must use DHH provided or approved materials and should refer members directly to the Enrollment Broker for needed assistance.

12.8. MCO Marketing Representative Guidelines

12.8.1. All MCO marketing representatives, including subcontractors assigned to marketing, must successfully complete a training program about the basic concepts of Louisiana Medicaid, Bayou Health and the enrollees' rights and responsibilities relating to enrollment in MCOs and grievance and appeals rights before engaging in direct marketing to potential enrollees..

12.8.2. The MCO shall ensure that all marketing representatives engage in professional and courteous behavior. The MCO shall not participate, encourage, or accept inappropriate behavior by its marketing representatives, including but not limited to interference with other MCO presentations or talking negatively about other MCOs.

12.8.3. The MCO shall not offer compensation to a marketing representative, including salary increases or bonuses, based solely on an overall increase in MCO enrollment. Compensation may be based on periodic performance evaluations which consider enrollment productivity as one of several performance factors.

12.8.4. Sign-on bonuses for marketing representatives are prohibited.

12.8.5. The MCO shall keep written documentation of the basis it uses for awarding bonuses or increasing the salary of marketing representatives and employees involved in marketing and make such documentation available for inspection by DHH.

12.9. Written Materials Guidelines

The MCO must comply with the following requirements as it relates to all written member materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.):

12.9.1. All member materials must be in a style and reading level that will accommodate the reading skills of MCO Enrollees. In general the writing should be at no higher than a 6.9 grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy:

- Flesch – Kincaid;
- Fry Readability Index;

- PROSE The Readability Analyst (software developed by Educational Activities, Inc.);
- Gunning FOG Index;
- McLaughlin SMOG Index; or
- Other computer generated readability indices accepted by DHH

12.9.2. All written materials must be clearly legible with a minimum font size of ten-point, preferably twelve-point, with the exception of Member ID cards, and or otherwise approved by DHH.

12.9.3. DHH reserves the right to require evidence that written materials for members have been tested against the 6.9 grade reading-level standard.

12.9.4. If a person making a testimonial or endorsement for an MCO has a financial interest in the company, such fact must be disclosed in the marketing materials.

12.9.5. All written materials must be in accordance with the **DHH "Person First" Policy**, Appendix NN.

12.9.6. The quality of materials used for printed materials shall be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans if applicable.

12.9.7. The MCO's name, mailing address (and physical location, if different) and toll-free number must be prominently displayed on the cover of all multi-paged marketing materials.

12.9.8. All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services;

12.9.9. All written materials related to MCO and PCP enrollment shall advise potential enrollees to verify with the medical services providers they prefer or have an existing relationship with, that such medical services providers are participating providers of the selected MCO and are available to serve the enrollee.

12.9.10. Alternative forms of communication must be provided upon request for persons with visual, hearing, speech, physical or developmental disabilities. These alternatives must be provided at no expense to the member.

12.9.11. Marketing materials must be made available through the MCO's entire service area. Materials may be customized for specific parishes and populations within the MCOs service area.

12.9.12. All marketing activities should provide for equitable distribution of materials without bias toward or against any group.

12.9.13. Marketing materials must accurately reflect general information, which is applicable to the average potential enrollee of the MCO.

12.9.14. The MCO Shall include in all member materials the following:

12.9.14.1. The date of issue;

12.9.14.2. The date of revision; and/or

12.9.14.3. If the prior versions are obsolete.

12.10. MCO Website Guidelines

12.10.1. The MCO website must include a member-focused section which can be a designated section of the MCO's general informational website, which is interactive and accessible using mobile devices, and has the capability for bidirectional communications, i.e. members can submit questions and comments to the MCO and receive responses.

12.10.2. The MCO website must include general and up-to-date information about its Bayou Health Plan as it relates to the Louisiana Medicaid program. This may be developed on a page within its existing website to meet these requirements.

12.10.3. The MCO must obtain prior written approval from DHH before updating the website.

12.10.4. The MCO must remain compliant with HIPAA privacy and security requirements when providing member eligibility or member identification information on the website.

12.10.5. The MCO website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern. The MCO web site must follow all written marketing guidelines included in this Section.

12.10.6. Use of proprietary items that would require a specific browser is not allowed.

12.10.7. The MCO must provide the following information on its website, and such information shall be easy to find, navigate, and understand by all members:

12.10.7.1. The most recent version of the Member Handbook;

12.10.7.2. Telephone contact information, including a toll-free customer service number prominently displayed and a Telecommunications Device for the Deaf (TDD) number;

12.10.7.3. A searchable list of network providers with a designation of open versus closed panels, shall be updated in real time, upon changes to the network;

12.10.7.4. The link to the Enrollment Broker's website (www.bayouhealth.com) and toll free number (1-855-BAYOU-4U, 1-855-229-6848) for questions about enrollment;

12.10.7.5. The link to the Medicaid website (www.medicaid.dhh.louisiana.gov) and the toll free number (888-342-6207) for questions about Medicaid eligibility;

12.10.7.6. A section for the MCO's providers that includes contact information, claims submittal information, prior authorization instructions, and a toll-free telephone number;

12.10.7.7. General customer service information; ~~and~~

12.10.7.8. Updates on emergency situations that may impact the public, such as natural and human-caused disasters that would require time sensitive action by members, such as evacuation from their homes or communities or other preparedness-related activities. The website shall include hyperlinks to state and federal emergency preparedness websites;

~~12.10.7.8.~~**12.10.7.9.** Information on how to file grievances and appeals; and~~.~~

12.10.7.10. Information specific to access for specialized behavioral health services, including but not limited to:

- The link to the DHH-OBH and CSoC websites;
- Information on how to access specialized behavioral health services;
- Crisis response information and toll-free crisis telephone numbers;
- Information regarding community forums, volunteer activities, and workgroups/committees that provide opportunities for members receiving services, their families/caregivers, providers, and stakeholders to become involved; and
- Information regarding advocacy organizations, including how members and other families/caregivers may access advocacy services.

12.11. ~~.~~Member Education – Required Materials and Services

The MCO shall ensure all materials and services do not discriminate against Medicaid MCO members on the basis of their health history, health status or need for health care services. This applies to enrollment, re-enrollment or disenrollment materials and processes from the MCO.

12.11.1. New Member Orientation

12.11.1.1. The MCO shall have written policies and procedures as applicable to the covered populations (see Section 3.3.3) for the following, but not limited to:

- Orienting new members of its benefits and services;
- Role of the PCP;
- What to do during the first thirty (30) to sixty (60) days after enrollment, (*e.g.* How to access services, continue medications, and obtain emergency or urgent medical services when transferring from FFS to MCO, or from one MCO to another, etc.);
- How to utilize services;

- What to do in an emergency or urgent medical situation; and
- How to a file a grievance and appeal.

12.11.1.2. The MCO shall identify and educate members who access the system inappropriately and provide continuing education as needed.

12.11.1.3. The MCO may propose, for approval by DHH, alternative methods for orienting new members and must be prepared to demonstrate their efficacy.

12.11.1.4. The MCO shall have written policies and procedures for notifying new members within ten (10) business days after receiving notification from the Enrollment Broker of enrollment. This notification must be in writing.

12.11.1.5. The MCO shall submit a copy of the procedures to be used to contact MCO members for initial member education to DHH for approval within thirty (30) days following the date the Contract is signed. These procedures shall adhere to the enrollment process and procedures outlined in this RFP and the Contract.

12.11.1.6. New Medicaid eligibleseligible shall be provided the opportunity to select a PCP within the MCO that: 1) 2) is accepting new members; 2) has, andhas entered into a subcontract with the MCO; and 3) is within a reasonable commuting distance from their residence.

12.11.2. Communication with New Enrollees

12.11.2.1. DHH's Enrollment Broker shall send the MCO a daily electronic transmission ANSI ACS X-12 834 as specified in the **MCO Systems Companion Guide**. The file shall contain the names, addresses and phone numbers of all newly eligible enrollees assigned to the MCO with an indicator for individuals who are automatically assigned to the MCO. The MCO shall use the file in assignment of PCPs and to identify and initiate communication with new members via welcome packet mailings and welcome calls, as prescribed in this RFP.

12.11.2.2. Welcome Packets

12.11.2.2.1. The MCO shall send a welcome packet to new members within ten (10) business days from the date of receipt of the ANSI ACS X-12 834 file identifying the new enrollee. During the integration of behavioral health into Bayou Health, an MCO shall have up to twenty-one (21) business days to send welcome packets; however, ID cards must be mailed within ten (10) business days.

12.11.2.2.2. The MCO must mail a welcome packet to each new member. When the name of the responsible party for the new member is associated with two (2) or more new members in the same eligibility group (as per Section 3.3.3),, the MCO is only required to send one welcome packet. If members are in different eligibility groups that equate to different levels of coverage, separate welcome packets for each type of coverage should be included.

12.11.2.2.3. All contents of the welcome packet are considered member materials and, as such, shall be reviewed and approved in writing by DHH prior to distribution according to the provisions described in this RFP. Contents of the welcome packets shall include those items specified in the Contract. The welcome packet shall include, but is not limited to:

- A Member Handbook and/or Welcome Member Newsletter;
- The MCO Member ID Card (if not mailed under a separate mailing);
- If the Member ID Card is mailed separately, a welcome letter highlighting major program features, details that a card specific to the MCO's Bayou Health Plan will be sent via mail separately and contact information for the MCO's Bayou Health Plan; and
- A current Provider Directory when specifically requested by the member (also must be available in searchable format on-line).

12.11.2.2.4. The MCO shall adhere to the requirements for the Member Handbook, Welcome Member Newsletter, ID card, and Provider Directory as specified in this RFP, its attachments, and in accordance with 42 CFR §438.10 (f)(6).

12.11.2.2.5. The MCO shall agree to make available the full scope of core benefits and services to which a member is entitled immediately upon his or her effective date of enrollment, which, with the exception of newborns, will always be the 1st day of a month.

12.11.2.3. Welcome Calls

12.11.2.3.1. The MCO shall make welcome calls to new members within fourteen (14) business days of the date the MCO sends the welcome packet. During the integration of behavioral health into Bayou Health, an MCO shall have up to twenty-one (21) business days to make welcome calls.

12.11.2.3.2. The MCO shall review PCP assignment if an automatic assignment was made and assist the member in changing the PCP if requested by the member.

12.11.2.3.3. The MCO shall develop and submit to DHH for approval a script(s), for all covered populations as specified in section 3.3.3, to be used during the welcome call to discuss the following information with the member:

- A brief explanation of the program;
- Statement of confidentiality;

- The availability of oral interpretation and written translation services and how to obtain them free of charge;

- The concept of the patient-centered medical home, including the importance of the member(s) making a first appointment with his or her PCP for preventive care before the member requires care due to an illness or condition and instructions about changing PCPs; and

- A discussion to discover whether the member is pregnant has a chronic condition, or any special health care needs. Assistance in making an appointment with the PCP shall be offered to all members with such issues.

12.11.2.3.4. The MCO shall make three (3) attempts to contact the member. If the MCO discovers that the member lost or never received the welcome packet, the MCO shall resend the packet.

12.11.3. Member Materials and Programs for Current Enrollees

The MCO shall develop and distribute member educational materials, including, but not limited to, the following:

12.11.3.1. A member-focused website which can be a designated section of the MCO's general informational website, and interactive media content such as a mobile device application, a mobile optimized website, or interactive social media;

12.11.3.2. Bulletins or newsletters distributed not less than two (2) times a year that provide information on preventive care, access to PCPs and other providers and other information that is helpful to members;

12.11.3.3. Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the MCO's Bayou Health Plan. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;

12.11.3.4. Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;

12.11.3.5. Materials focused on health promotion programs available to the members;

12.11.3.6. Communications detailing how members can take personal responsibility for their health and self-management;

12.11.3.7. Materials that promote the availability of health education classes for members;

12.11.3.8. Materials that provide education for members, with, or at risk for, a specific disability or illness;

12.11.3.9. Materials that provide education to members, members' families and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities;

12.11.3.10. Notification to its members of their right to request and obtain the welcome packet (including all items noted in Section 12.11.2.1 except for the Member ID card) at least once a year;

12.11.3.11. Notification to its members of any change that DHH defines as significant at least thirty (30) calendar days before the intended effective date; and

12.11.3.12. All materials distributed must comply with the relevant guidelines established by DHH for these materials and/or programs.

12.12. MCO Member Handbook

12.12.1. The MCO shall develop and maintain separate~~a~~ member handbook~~s~~ that adhere~~s~~ to the requirements in 42 CFR §438.10(f)(6) for each of the covered populations as specified in section 3.3.3.)~~.~~

12.12.1.1. At a minimum, the member handbook shall include the following information, as applicable to the covered population that is the audience for the handbook (see Section 3.3.3):~~:~~

12.12.1.2. Table of contents;

12.12.1.3. A general description about how MCOs operate, member rights and responsibilities, appropriate utilization of services including ED for non-emergent conditions, a description of the PCP selection process, and the PCP's role as coordinator of services;

12.12.1.4. Member's right to disenroll from MCO including disenrollment for cause;

12.12.1.5. Member's right to change providers within the MCO;

12.12.1.6. Any restrictions on the member's freedom of choice among MCO providers;

12.12.1.7. Member's rights and protections, as specified in 42 CFR §438.100 and this RFP;

12.12.1.8. The amount, duration, and scope of benefits available to the member under the contract between the MCO and DHH in sufficient detail to ensure that members understand the benefits to which they are entitled, including specialized behavioral health benefits and information about health education and promotion programs, including chronic care management;

12.12.1.9. Procedures for obtaining benefits, including authorization requirements;

12.12.1.10. Description on the purpose of the Medicaid card and the MCO card and why both are necessary and how to use them;

12.12.1.11. The extent to which, and how, members may obtain benefits, including family planning services ~~and specialized behavioral health services~~ from out-of-network providers;

12.12.1.12. The extent to which, and how, after-hours, crisis and emergency coverage are provided, including:

- What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR §438.114(a);
- That prior authorization is not required for emergency services;
- The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent;
- The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered by the MCO; and
- That, subject to the provisions of 42 CFR Part 438, the member has a right to use any hospital or other setting for emergency care.

12.12.1.13. The post-stabilization care services rules set forth in 42 CFR §422.113(c);

12.12.1.14. Policy on referrals for specialty care, including **specialized** behavioral health services and for other benefits not furnished by the member's PCP;

12.12.1.15. How and where to access any benefits that are available under the Louisiana Medicaid State Plan but, are not covered under the MCO's contract with DHH;

12.12.1.16. That the member has the right to refuse to undergo any medical service, diagnoses, or treatment or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects)on religious grounds;

12.12.1.17. For counseling or referral services that the MCO does not cover because of moral or religious objections, the MCO should direct the member to contact the Enrollment Broker for information on how or where to obtain the service;

12.12.1.18. Member grievance, appeal and state fair hearing procedures and time frames, as described in 42 CFR §438.400-424 and this RFP;

12.12.1.19. Grievance, appeal and fair hearing procedures that include the following:

- For State Fair Hearing:
  - The right to a hearing;
  - The method for obtaining a hearing; and
  - The rules that govern representation at the hearing.
- The right to file grievances and appeals;

- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The toll-free numbers that the member can use to file a grievance or an appeal by phone;
- The fact that, when requested by the member:
    - Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and
    - The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.
- In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of the DHH who has final authority to determine whether services must be provided.

12.12.1.20. Advance Directives, as set forth in 42 CFR §438.6(i)(1) - A description of advance directives which shall include:

- The MCO policies related to advance directives;
- The member's rights under Louisiana state law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change;
- Information that members can file complaints about the failure to comply with an advance directive with the Office of Health Standards, Louisiana's Survey and Certification agency) by calling 225 342 0138; and
- Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.

12.12.1.21. Information to call the Medicaid Customer Service Unit toll free hotline, go to Louisiana Medicaid website at www.medicaid.la.gov, or visit a regional Medicaid eligibility office to report if family size, living arrangements, parish of residence, or mailing address changes;

12.12.1.22. How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show;"

12.12.1.23. A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;

12.12.1.24. How to obtain emergency and non-emergency medical transportation;

12.12.1.25. Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;

12.12.1.26. Information about the requirement that a member shall notify the MCO immediately if he or she has a Worker's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in an auto accident;

12.12.1.27. Reporting requirements for the member that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported to the MCO;

12.12.1.28. Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the MCO or DHH. This shall include a statement that the member is responsible for protecting their ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;

12.12.1.29. Instructions on how to request multi-lingual interpretation and translation when needed at no cost to the member. This instruction shall be included in all versions of the handbook in English and Spanish;

12.12.1.30. Information on the member's right to a second opinion in accordance with 42 CFR §438.206(b)(3) at no cost and how to obtain it;

12.12.1.31. Ways to report suspected provider fraud and abuse including but not limited to DHH and MCO toll-free numbers and website established for that purpose;

12.12.1.32. Any additional text provided to the MCO by DHH or deemed essential by the MCO;

12.12.1.33. The date of the last revision;

12.12.1.34. Additional information that is available upon request, including the following:

- Information on the structure and operation of the MCO;
- Physician incentive plans [42 CFR §438.6(h)].
- Service utilization policies; and
- How to report alleged marketing violations to DHH utilizing the **Marketing Complaint Form**. (See Appendix Z of this RFP)

12.12.1.35. Information regarding specialized behavioral health services, including but not limited to:

- A description of covered behavioral health services;
- Where and how to access behavioral health services and behavioral health providers;
- General information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult engagement; resilience; strength-based and evidence-based practice; and best/proven practices;

- Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and
- Any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment as per 42 CFR Part 2.

~~12.12.1.35.~~12.12.1.36. At least once a year, the MCO must notify the member of their option of receiving either the Member Handbook or the member Welcome Newsletter in either electronic format or hardcopy, upon request from the member.

~~12.12.1.36.~~12.12.1.37. The MCO shall review and update the Member Handbook at least once a year. The Handbook must be submitted to DHH for approval within four weeks of the annual renewal and upon any changes prior to being made available to members.

~~12.12.1.37.~~12.12.1.38. **MCO Welcome Newsletter**

~~12.12.1.37.1.~~12.12.1.38.1. Should the MCO elect not to provide a Member Handbook hard copy at the time of sending the welcome packet for new members, the MCO shall develop and maintain a welcome newsletter that adheres to the requirements in 42 CFR §438.10.

~~12.12.1.37.2.~~12.12.1.38.2. The MCO shall review and update the Welcome Member Newsletter at least once a year. The Newsletter must be submitted to DHH for approval within four weeks of the annual renewal and upon any changes prior to being made available to members

~~12.12.1.37.3.~~12.12.1.38.3. At a minimum, eachthe welcome member newsletter shall include the following information as it applies to the covered populations as specified in section 3.3.3.:~~:~~

- Right to request an updated Member Handbook at no cost to the member. Notification that the Handbook is available on the Contractor's website, by electronic mail or through postal mailing must be referenced;
- ~~-~~Member Grievance and Appeal rights;
- Right to access oral interpretation services, free of charge, and how to access them that adheres to the requirements in 42 CFR §438.10(4) and (5);
- MCO service hours and availability with contact information including but not limited to Member Services, Nurse Line, Behavioral Health Crisis Line~~MCO~~, Dental Benefit Manager, Reporting suspected Fraud and Abuse, Pharmacy Benefit Manager, and Transportation;
- Tobacco Cessation Information with a website link to tobacco education and prevention program;

- Information on how to search for providers, including specialized behavioral health providers, and how to obtain, at no charge, a directory of providers;
- Information on what to do if a member is billed, and under what circumstances a member may be billed for non-covered services;
- How to file a grievance;
- What to do in case of an emergency, information on proper emergency service utilization, and the right to obtain emergency services at any hospital or other ED facility, in or out of network;
- Description of fraud, waste, and abuse, including instruction on how to report suspect fraud, waste, and abuse;
- Right to be treated fairly regardless of race, religion, gender, age, and ability to pay;
- Right to request a medical record copy and/or inspect medical records at no cost as specified in 45 CFR Part 164;
- How to access afterhours care;
- How to change Health Plans;
- Instructions on changing your PCP;
- Instructions where to find detailed listing of covered benefits; ~~and~~
- Identification of services for which copays are applicable; and
- Specialized behavioral health services information, including where and how to access behavioral health services (including emergency or crisis services).~~.~~

12.13. Member Identification (ID) Cards

12.13.1. MCO members will be issued at a minimum two (2) different member identification cards related to their enrollment in the Louisiana Medicaid managed care delivery system. The MCO may opt to provide members with a third ID card, if the MCO elects to issue a separate pharmacy-related ID card.

12.13.2. A DHH issued ID card will be issued to all Medicaid eligibles, including MCO members. This card is not proof of eligibility, but can be used for accessing the state's electronic eligibility verification systems by MCO providers. These systems will contain the most current information available to DHH, including specific information regarding MCO enrollment. There will be no MCO specific information printed on the card. The MCO member may need to show this card to access Medicaid services not included in the MCO core benefits and services.

12.13.3. An MCO-issued member ID card that contains information specific to the MCO. The member's ID card shall at a minimum include, but not be limited to, the following information as it applies to the covered populations as specified in section 3.3.3:

- The member's name and date of birth;
- The MCO's name and address;

- Instructions for emergencies;
- The PCP's name and telephone numbers (including after-hours number, if different from business hours number);
- The toll-free number(s) for:
  - 24-hour Nurse Line
  - The Member Services Line
  - and Filing Grievances
  - 24-hour behavioral health crisis line
  - Provider Services and Prior Authorization and
  - Reporting Medicaid Fraud (1-800-488-2917)

12.13.3.1. The MCO may provide the MCO Member ID card in a separate mailing from the welcome packet, however the card must be sent no later than ten (10) business days from the date of receipt of the file from DHH or the Enrollment Broker identifying the new enrollee. As part of the welcome packet information, the MCO must explain the purpose of the card, how to use the card, and how to use it in tandem with the DHH-issued card.

12.13.3.2. The card will be issued without the PCP information if no PCP selection has been made on the date of the mailing.

12.13.3.3. Once PCP selection has been made by the member or through auto assignment, the MCO will reissue the card in keeping with the time guidelines of this RFP and the Contract. As part of the mailing of the reissued card, the MCO must explain the purpose of the reissued card, the changes between the new card and the previous card, and what the enrollee should do with the previous card.

12.13.3.4. The MCO shall reissue the MCO ID card within ten (10) calendar days of notice that a member reports a lost card, there is a member name change or the PCP changes, or for any other reason that results in a change to the information on the member ID card.

12.13.3.5. The holder of the member identification card issued by the MCO shall be an MCO member or guardian of a member. If the MCO has knowledge of any MCO member permitting the use of this identification card by any other person, the MCO shall immediately report this violation to the Medicaid Fraud Hotline number 1-800-488-2917.

12.13.3.6. The MCO shall ensure that its subcontractors can identify members in a manner which will not result in discrimination against the members, in order to provide or coordinate the provision of all **core** benefits and services and/or expanded services and out of network services.

12.13.4. Pharmacy-Related ID Card Requirements

12.13.4.1. The MCO shall provide on the member's identification card, or on a separate prescription benefit card, or through other technology, prescription billing information that:

12.13.4.1.1. Complies with the standards set forth in the National Council for Prescription Drug Programs pharmacy ID card prescription benefit card implementation guide at the time of issuance of the card or other technology; or

12.13.4.1.2. Includes, at a minimum, the following data elements:

12.13.4.1.2.1. The name or identifying trademark of the MCO and the prescription benefit manager (see co-branding restrictions in Section 12.20.3);

12.13.4.1.2.2. The name and MCO member identification number of the recipient;

12.13.4.1.2.3. The telephone number that providers may call for:

- Pharmacy benefit assistance;
- 24-hour member services and filing grievances;
- Provider services and prior authorization; and
- Reporting Medicaid Fraud (1-800-488-2917)

12.13.4.1.3. All electronic transaction routing information and other numbers required by the MCO or its benefit administrator to process a prescription claim electronically.

12.13.4.1.4. If the MCO chooses to include the prescription benefit information on the Bayou Health Plan card, the MCO must ensure all members have a card that includes all necessary prescription benefit information, as outlined above.

12.13.4.1.5. If the MCO chooses to provide a separate prescription benefit card, the card mailer that accompanies the card must include language that explains the purpose of the card, how to use the card and how to use it in tandem with the DHH-issued Medicaid Card and the MCO-issued card.

12.14. Provider Directory for Members

12.14.1. The MCO shall develop and maintain a Provider Directory in four (4) formats:

12.14.1.1. A hard copy directory, when requested, for members and potential members;

12.14.1.2. Web-based, searchable, online directory for members and the public;

12.14.1.3. Electronic file of the directory to be submitted and updated weekly to the Medicaid FI or other designee as determined by DHH; for the Enrollment Broker; and

12.14.1.4. Hard copy, abbreviated version upon request by the Enrollment Broker.

12.14.2. The MCO shall submit templates of its provider directory to DHH within thirty (30) days from the date the Contract is signed.

12.14.3. The hard copy directory for members shall be revised with updates at least annually. Inserts may be used to update the hard copy directories monthly to fulfill requests by members and potential members. The web-based online version shall be updated in real time, but no less than weekly. While daily updates are preferred, the MCO shall at a minimum submit no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be available to all Medicaid enrollees when requested by contacting the Enrollment Broker. Format for this version will be in a format specified by DHH.

12.14.4. In accordance with 42 CFR §438.10(f)(6), the provider directory shall include, but not be limited to:

12.14.4.1. Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Medicaid enrollee's service area, including identification of providers, PCPs, behavioral health and other specialists, and hospitals at a minimum, that are not accepting new patients;

12.14.4.2. Identification of qualified providers divided into specific provider and service types and specializations, including but not limited to, primary care physicians, specialists, hospital~~and hospitals~~ PCP groups, clinic settings, home and community-based services, outpatient therapy, residential substance use, youth residential services, inpatient mental health and residential substance use services, and FQHCs and RHCs in the service area. This shall include a child serving list that is both monitored and frequently updated to ensure viable options are identified and available for OJJ, DCFS and LDOE field staff. The MCO provider types shall be delineated by parish and zip code; ~~;~~

12.14.4.3. Identification of any restrictions on the enrollee's freedom of choice among network providers; and

12.14.4.4. Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours).

12.14.4.5. DHH reserves the right to request additional data needed for enhancements to the provider search function.

12.14.5. To assist Medicaid potential enrollees in identifying participating providers for each MCO, the Enrollment Broker will maintain and update weekly an electronic provider directory that is accessible through the website www.bayouhealth.com and will make available, (by mail) paper provider directories which comply with the member material requirements of this RFP.

12.15. Member Call Center

12.15.1. The MCO shall maintain a toll-free member service call center, physically located in the United States, with dedicated staff to respond to member questions including, but not limited to, such topics as:

12.15.1.1. Explanation of MCO policies and procedures;

12.15.1.2. Prior authorizations;

12.15.1.3. Access information;

12.15.1.4. Information on PCPs or specialists;

12.15.1.5. Referrals to participating specialists;

12.15.1.6. Resolution of service and/or medical or behavioral health delivery problems;

~~12.15.1.6.~~**12.15.1.7.** Member rights and responsibilities;

12.15.1.8. Coordination of support services available through Medicaid or community organizations;

~~12.15.1.7.~~**12.15.1.9.** Member grievances; and~~.~~

12.15.1.10. Information on Specialized Behavioral Health Services and Providers

12.15.2. The toll-free number must be staffed between the hours of 7 a.m. and 7 p.m. Central Time, Monday through Friday, excluding state-declared holidays.

12.15.3. The toll-free line shall have an automated system, available 24-hours a day, seven-days a week. This automated system must include the capability of providing callers with operating instructions on what to do in case of an emergency and the option to talk directly to a nurse or other clinician or leave a message, including instructions on how to leave a message and when that message will be returned. The MCO must ensure that the voice mailbox has adequate capacity to receive all messages and that member services staff return all calls by close of business the following business day.

12.15.4. The MCO shall have sufficient telephone lines to answer incoming calls. The MCO shall ensure sufficient staffing to meet performance standards listed in this RFP. DHH reserves the right to specify staffing ratio and/or other requirements, if performance standards are not met or it is determined that the call center staffing/processes are not sufficient to meet member needs as determined by DHH.

12.15.5. The MCO must develop a contingency plan for hiring call center staff to address overflow calls and emails and to maintain call center access standards set forth for MCO performance. The MCO must develop and implement a plan to sustain call center performance levels in situations where there is high call/e-mail volume or low staff availability. Such situations may include, but are not limited to, increases in call volume, emergency situations (including natural disasters such as hurricanes), staff in training, staff illnesses and vacations.

12.15.6. The MCO must develop telephone help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards and emergencies including but not limited to hurricane-related evacuations. The MCO shall submit these telephone help line policies and procedures, including performance standards, to DHH for written approval prior to implementation of any policies. This must include a capability to track and report information on each call. The MCO call center must have the capability to produce an electronic

record to document a synopsis of all calls. The tracking shall include sufficient information to meet the reporting requirements.

12.15.7. The MCO shall develop call center quality criteria and protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the toll-free telephone line. The MCO shall submit call center quality criteria and protocols to DHH for review and approval annually.

12.15.8. The MCO shall provide general assistance and information to individuals and their families seeking to understand how to access care. For CSoC eligible members, provide information to families about the specialized services and how to contact the contractor.

12.16. 24-hour Behavioral Health Crisis Line

12.16.1. The MCO shall maintain a 24-hour toll-free crisis response center to respond to specialized behavioral health needs. The call center may be combined with the MCO's 24-hour nurse line or may be a separate line, but must provide the following:

12.16.1.1. 24-hour, 7-day a week access to staff;

12.16.1.2. Answered by a live voice at all times; and

12.16.1.3. Have sufficient telephone lines to answer incoming calls.

12.16.2. The MCO shall assist and triage callers who may be in crisis by effectuating an immediate transfer to a care manager. The call shall be answered within thirty (30) seconds and only transferred via a warm line to a LMHP. The MCO shall respect the caller's privacy during all communications and calls

~~12.16.~~12.17. ACD System

The MCO shall install, operate, and monitor an automated call distribution (ACD) system for the customer service telephone call center. The ACD system shall:

~~12.16.1.~~12.17.1. Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;

~~12.16.2.~~12.17.2. Transfer calls to other telephone lines;

~~12.16.3.~~12.17.3. Provide detailed analysis as required for the reporting requirements, as specified, including the quantity, length and types of calls received, elapsed time before the calls are answered, the number of calls transferred or referred; abandonment rate; wait time; busy rate; response time; and call volume;

~~12.16.4.~~12.17.4. Provide a message that notifies callers that the call may be monitored for quality control purposes;

~~12.16.5.~~12.17.5. Measure the number of calls in the queue;

~~12.16.6.~~12.17.6. Measure the length of time callers are on hold;

~~12.16.7.~~12.17.7. Measure the total number of calls and average calls handled per day/week/month;

~~12.16.8.~~12.17.8. Measure the average hours of use per day;

~~12.16.9.~~12.17.9. Assess the busiest times and days by number of calls;

~~12.16.10.~~12.17.10. Record calls to assess whether answered accurately;

~~12.16.11.~~12.17.11. Provide a backup telephone system that shall operate in the event of line trouble, emergency situations including natural disasters, or other problems so that access to the telephone lines are not disrupted;

~~12.16.12.~~12.17.12. Provide interactive voice response (IVR) options that are user-friendly to members and include a decision tree illustrating IVR system; and

~~12.16.13.~~12.17.13. Inform the member to dial 911 if there is an emergency.

~~12.16.14.~~12.17.14. **Call Center Performance Standards**

~~12.16.14.1.~~12.17.14.1. Answer ninety-five (95) percent of calls within thirty (30) seconds or direct the call to an automatic call pickup system with IVR options;

~~12.16.14.2.~~12.17.14.2. No more than one percent (1%) of incoming calls receive a busy signal;

~~12.16.14.3.~~12.17.14.3. Maintain an average hold time of three (3) minutes or less. Hold time, or wait time, for the purposes of this RFP includes 1) the time a caller spends waiting for a customer service representative to assist them after the caller has navigated the IVR system and requested a live person; and 2) the measure of time when a customer service representative places a caller on hold.

~~12.16.14.4.~~12.17.14.4. Maintain abandoned rate of calls of not more than five (5) percent.

~~12.16.14.4.1.~~12.17.14.4.1. The MCO must conduct ongoing quality assurance to ensure these standards are met.

~~12.16.14.4.2.~~12.17.14.4.2. If DHH determines that it is necessary to conduct onsite monitoring of the MCO's member call center functions, the MCO is responsible for all reasonable costs incurred by DHH or its authorized agent(s) relating to such monitoring.

~~12.16.15.~~12.17.15. **Members' Rights and Responsibilities**

~~12.16.15.1.~~12.17.15.1. The MCO shall have written policies regarding member rights and responsibilities. The MCO shall comply with all applicable state and federal laws pertaining to member rights and privacy. The MCO shall further ensure that the MCO's employees, contractors and MCO providers consider and respect those rights when providing services to members.

~~12.16.15.2.~~12.17.15.2. Member's Rights -The rights afforded to current members are detailed in Appendix AA, **Members' Bill of Rights**.

~~12.16.16.~~12.17.16. Member Responsibilities

~~12.16.16.1.~~12.17.16.1. The MCO shall encourage each member to be responsible for his own health care by becoming an informed and active participant in their care. Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their health care provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.

~~12.16.16.2.~~12.17.16.2. The MCO members' responsibilities shall include but are not limited to:

- Informing the MCO of the loss or theft of their ID card;
- Presenting their MCO ID card when using health care services;
- Being familiar with the MCO procedures to the best of the member's abilities;
- Calling or contacting the MCO to obtain information and have questions answered;
- Providing participating network providers with accurate and complete medical information;
- Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible;
- Living healthy lifestyles and avoiding behaviors known to be detrimental to their health;
- Following the grievance process established by the MCO if they have a disagreement with a provider; and
- Making every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.

~~12.17.~~12.18. Notice to Members of Provider Termination

~~12.17.1.~~12.18.1. The MCO shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.

~~12.17.2.~~12.18.2. The MCO shall provide notice to a member, or the parent/legal guardian and the involved state agency as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven (7~~ten (10~~) calendar days from the date the MCO becomes aware of such, if it is prior to the change occurring.

Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the MCO becoming aware of the circumstances.

~~12.18.~~12.19. Oral Interpretation and Written Translation Services

~~12.18.1.~~12.19.1. In accordance with 42 CFR §438.10(b)(1) DHH shall provide on its website the prevalent non-English languages spoken by enrollees in the state.

~~12.18.2.~~12.19.2. The MCO must make real-time oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages not just those that Louisiana specifically requires (Spanish). The enrollee is not to be charged for interpretation services. The MCO must notify its enrollees that oral interpretation is available for any language and written information is available in Spanish and how to access those services. On materials where this information is provided, the notation should be written in Spanish.

~~12.18.3.~~12.19.3. The MCO shall ensure that translation services are provided for all written marketing and member materials for any language that is spoken as a primary language for four percent (4%) or more enrollees, or potential enrollees of an MCO. Within ninety (90) calendar days of notice from DHH, materials must be translated and made available. Materials must be made available at no charge in that specific language to assure a reasonable chance for all members to understand how to access the MCO and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).

~~12.19.~~12.20. Marketing Reporting and Monitoring

~~12.19.1.~~12.20.1. Reporting to DHH

~~12.19.1.1.~~12.20.1.1. A summary report of all marketing and member education efforts must be submitted to DHH within thirty (30) days of the end of the calendar year using a **Marketing Plan Annual Review** format guidance provided by DHH.

~~12.19.2.~~12.20.2. Reporting Alleged Marketing Violations

~~12.19.2.1.~~12.20.2.1. To ensure the fair and consistent investigation of alleged violations, DHH has outlined the following reporting guidelines:

~~12.19.2.2.~~12.20.2.2. Alleged marketing violations must be reported to DHH in writing utilizing the ***Marketing Complaint Form***, (See Appendix Z).

~~12.19.2.3.~~12.20.2.3. Upon written receipt of allegations, DHH will:

- Acknowledge receipt, in writing, within five (5) business days from the date of receipt of the allegation.
- Begin investigation within five (5) business days from receipt of the allegation and complete the investigation within thirty (30) calendar days. DHH may extend the time for investigation if there are extenuating circumstances.
- Analyze the findings and take appropriate action (see Section 20 of this RFP, for additional details).
- Notify the complainant after appropriate action has been taken.

~~12.19.3.~~12.20.3. **Sanctions**

DHH may impose sanctions against the MCO for marketing and member education violations as outlined in Section 20 of this RFP.

~~12.20.~~12.21. **Pharmacy-Related Marketing and Member Education**

~~12.20.1.~~12.21.1. The MCO and all subcontractors, including PBMs and providers, are subject to the Marketing and Member Education requirements set forth in Section 12.1 – 12.10 of the contract. This includes the review and approval of all marketing and member materials including, but not limited to, websites and social media, ID cards, call scripts for outbound calls or customer service centers, provider directories, advertisement and direct member mailings.

~~12.20.2.~~12.21.2. Members of an MCO must have free access to any pharmacy participating in the MCO's network (except in cases where the member is participating in the pharmacy lock-in program). Neither the MCO nor any subcontractor is allowed to steer members to certain network providers. DHH retains the discretion to deny the use of marketing and member material that it deems to promote undue patient steering.

~~12.20.3.~~12.21.3. MCO are prohibited from displaying the names and/or logos of co-branded PBMs on the MCO's member identification card. MCOs that choose to co-brand with providers must include on marketing materials (other than ID cards) the following language: "Other Pharmacies are Available in Our Network."

~~12.20.4.~~12.21.4. Co-branded marketing materials must be submitted to DHH by the MCO for approval.

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13.0 MEMBER GRIEVANCE AND APPEALS PROCEDURES

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

The MCO's grievance and appeals procedures and any changes thereto must be approved in writing by DHH prior to their implementation and must include at a minimum the requirements set forth in this RFP.

The MCO shall refer all MCO members who are dissatisfied with the MCO or its subcontractor in any respect to the MCO's designee authorized to review and respond to grievances and appeals and require corrective action.

The member must exhaust the MCO's internal grievance/appeal procedures prior to accessing the State Fair Hearing process.

The MCO shall not create barriers to timely due process. The MCO shall be subject to sanctions if it is determined by DHH that the MCO has created barriers to timely due process, and/or, if ten (10) percent or higher of appeal decisions appealed to the State Fair Hearing level within a twelve (12) month period have been reversed or otherwise resolved in favor of the member. Examples of creating barriers shall include but not be limited to:

- Including binding arbitration clauses in MCO member choice forms;
- Labeling grievances as inquiries and funneled into an informal review;
- Failing to inform members of their due process rights;
- Failing to log and process grievances and appeals;
- Failure to issue a proper notice including vague or illegible notices;
- Failure to inform of continuation of benefits; and
- Failure to inform of right to State Fair Hearing.

13.1. Applicable Definitions – See Glossary

13.2. General Grievance System Requirements

13.2.1. Grievance System

The MCO must have a system in place for members that include a grievance process, an appeal process, and access to the State Fair Hearing system, once the MCO's appeal process has been exhausted.

13.2.2. Filing Requirements

13.2.2.1. Authority to File

13.2.2.1.1. A member, or authorized representative acting on the member's behalf, may file a grievance and an MCO level appeal, and may

request a State Fair Hearing, once the MCO's appeals process has been exhausted.

13.2.2.1.2. A network provider, acting on behalf of the member and with the member's written consent, may file an appeal. A network provider may file a grievance or request a State Fair Hearing on behalf of a member.

13.2.3. Time Limits for Filing

The member must be allowed thirty (30) calendar days from the date on the MCO's notice of action or inaction to file a grievance or appeal. Within that timeframe the member or a representative acting on their behalf and with the member's written consent may file an appeal or the provider may file an appeal on behalf of the member, and with the member's written consent.

13.2.4. Procedures for Filing

13.2.4.1. The member or the provider may file an appeal either orally or in writing.

13.2.4.2. The MCO shall ensure that all MCO members are informed of the State Fair Hearing process and of the MCO's grievance and appeal procedures. The MCO shall provide to each member a member handbook that shall include descriptions of the MCO's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the MCO shall be available through the MCO, and must be provided upon request of the member. The MCO shall make all forms easily available on the MCO's website.

13.3. Grievance/Appeal Records and Reports

13.3.1. The MCO must maintain records of all grievances and appeals. A copy of grievances logs and records of disposition of appeals shall be retained for six (6) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six (6) year period, whichever is later.

13.3.2. The MCO shall electronically provide DHH with a monthly report of the grievances/appeals in accordance with the requirements outlined in this RFP, to include, but not be limited to: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; resolution and resulting corrective action. Reports with personally identifying information redacted will be made available for public inspection.

13.3.3. The MCO will be responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the MCO member. DHH may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance/appeal.

13.4. Handling of Grievances and Appeals

13.4.1. General Requirements

In handling grievances and appeals, the MCO must meet the following requirements:

13.4.1.1. Acknowledge receipt of each grievance and appeal in writing within five (5) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the monthly grievance log;

13.4.1.2. Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;

13.4.1.3. Ensure that the individuals who make decisions on grievances and appeals are individuals:

13.4.1.3.1. Who were not involved in any previous level of review or decision-making; and

13.4.1.3.2. Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by DHH, in treating the member's condition or disease:

- An appeal of a denial that is based on lack of medical necessity.
- A grievance regarding denial of expedited resolution of an appeal.
- A grievance or appeal that involves clinical issues.

13.4.2. Special Requirements for Appeals

The process for appeals must:

13.4.2.1. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal). The member, member's authorized representative or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional enrollee follow-up is required.

13.4.2.2. Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO must inform the member of the limited time available for this in the case of expedited resolution).

13.4.2.3. Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process.

13.4.2.4. Include, as parties to the appeal:

- The member and his or her representative; or
- The legal representative of a deceased member's estate.

13.4.3. Training of MCO Staff

The MCO's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.

13.4.4. Identification of Appropriate Party

The appropriate individual or body within the MCO having decision making authority as part of the grievance/appeal procedure shall be identified.

13.4.5. Failure to Make a Timely Decision

Appeals shall be resolved no later than stated time frames and all parties shall be informed of the MCO's decision. If a determination is not made in accordance with the timeframes specified in Section 13.7 of this RFP, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

13.4.6. Right to State Fair Hearing

The MCO shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the MCO's decision in response to an appeal and the process for doing so.

13.5. Notice of Action

13.5.1. Language and Format Requirements

The notice must be in writing and must meet the language and format requirements of 42 CFR §438.10(c) and (d) and Section 12. of this RFP to ensure ease of understanding.

13.5.2. Content of Notice of Action

The Notice of Action must explain the following:

13.5.2.1. The action the MCO or its contractor has taken or intends to take;

13.5.2.2. The reasons for the action;

13.5.2.3. The member's right to file an appeal with the MCO;

13.5.2.4. The member's right to request a State Fair Hearing, after the MCO's appeal process has been exhausted;

13.5.2.5. The procedures for exercising the rights specified in this Section;

13.5.2.6. The circumstances under which expedited resolution is available and how to request it;

13.5.2.7. The member's right to have benefits continued pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services; and

13.5.2.8. Oral interpretation is available for all languages and how to access it.

13.5.3. Timing of Notice of Action

The MCO must mail the Notice of Action within the following timeframes:

13.5.3.1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action, except:

13.5.3.1.1. The period of advanced notice is shortened to five (5) days if probable member fraud has been verified or by the date of action for the following:

- in the death of a recipient
- a signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);
- the recipient's admission to an institution where he is eligible for further services;
- the recipient's address is unknown and mail directed to him has no forwarding address;
- the recipient has been accepted for Medicaid services by another local jurisdiction; or
- the recipient's physician prescribes the change in the level of medical care; or
- as otherwise permitted under 42 CFR §431.213.

13.5.3.2. For denial of payment, at the time of any action affecting the claim.

13.5.3.3. For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if:

13.5.3.3.1. The member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or

13.5.3.3.2. The MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.

13.5.3.4. If the MCO extends the timeframe in accordance with Section 13.5.3.3.1 or 13.5.3.3.2 above, it must:

- Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and

- Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

13.5.3.5. On the date the timeframe for service authorization as specified in Section 13.6.3.3 expires. Untimely service authorizations constitute a denial and are thus adverse actions.

13.5.3.6. For expedited service authorization decisions where a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.

13.5.3.7. The MCO may extend the seventy-two (72) hours' time period by up to fourteen (14) calendar days if the member requests an extension, or if the MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.

13.5.3.8. DHH will conduct random reviews to ensure that members are receiving such notices in a timely manner.

13.6. Resolution and Notification

The MCO must dispose of a grievance and resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within the timeframes established in Section 13.16.1 below.

13.6.1. Specific Timeframes

13.6.1.1. Standard Disposition of Grievances
For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the MCO receives the grievance.

13.6.1.2. Standard Resolution of Appeals
For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the MCO receives the appeal. This timeframe may be extended under Section 13.7.2 of this Section.

13.6.1.3. Expedited Resolution of Appeals
For expedited resolution of an appeal and notice to affected parties, the timeframe is established as seventy-two (72) hours after the MCO receives the appeal. This timeframe may be extended under Section 13.7.2 of this Section.

13.6.2. Extension of Timeframes

13.6.2.1. The MCO may extend the timeframes from Section 13.6.1 of this Section by up to fourteen (14) calendar days if:

- The member requests the extension; or
- The MCO shows (to the satisfaction of DHH, upon its request) that there is need for additional information and how the delay is in the member's interest.

13.6.2.2. Requirements Following Timeframe Extension
If the MCO extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.

13.6.3. Format of Notice of Disposition

13.6.3.1. Grievances
The MCO will provide written notice to the member of the disposition of a grievance.

13.6.3.2. Appeals
For all appeals, the MCO must provide written notice of disposition.

For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.

13.6.4. Content of Notice of Appeal Resolution

13.6.4.1. The written notice of the resolution must include the following:

- The results of the resolution process and the date it was completed.

13.6.4.2. For appeals not resolved wholly in favor of the members:

- The right to request a State Fair Hearing, and how to do so;
- The right to request to receive benefits while the hearing is pending, and how to make the request; and
- That the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.

13.6.5. Requirements for State Fair Hearings

DHH shall comply with the requirements of 42 CFR §431.200(b), §431.220(5), §438.414 and §438.10(g)(1). The MCO shall comply with all requirements as outlined in this RFP.

13.6.5.1. Availability
If the member has exhausted the MCO-level appeal procedures, the member may request a State Fair Hearing within thirty (30) days from the date of the MCO's notice of resolution.

13.6.5.2. Parties

The parties to the State Fair Hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate.

13.7. Expedited Resolution of Appeals

The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider, acting on behalf of the member and with the member's written consent, indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

13.7.1. Prohibition Against Punitive Action

The MCO must ensure that punitive action is not taken against a provider, acting on behalf of the member and with the member's written consent, who requests an expedited resolution or supports a member's appeal.

13.7.2. Action Following Denial of a Request for Expedited Resolution

If the MCO denies a request for expedited resolution of an appeal, it must:

13.7.2.1. Transfer the appeal to the timeframe for standard resolution in accordance with Section **13.7.1.2**;

13.7.2.2. Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

13.7.2.3. This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.

13.7.3. Failure to Make a Timely Decision

Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the MCO's decision. If a determination is not made by the above timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

13.7.4. Process

13.7.4.1. The MCO is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional follow-up may be required.

13.7.4.2. The MCO shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

13.7.5. Authority to File

The Medicaid member or their provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional member follow-up is required.

13.7.6. Format of Resolution Notice

In addition to written notice, the MCO must also make reasonable effort to provide oral notice.

13.8. Continuation of Benefits

13.8.1. Terminology

As used in this Section, “timely" filing means filing on or before the later of the following:

13.8.1.1. Within ten (10) days of the MCO mailing the notice of action, or

13.8.1.2. The intended effective date of the MCO's proposed action.

13.8.2. Continuation of Benefits

The MCO must continue the member's benefits if:

13.8.2.1. The member or the provider, acting on behalf of the member and with the member's written consent, files the appeal timely;

13.8.2.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

13.8.2.3. The services were ordered by an authorized provider;

13.8.2.4. The original period covered by the original authorization has not expired; and

13.8.2.5. The member requests an extension of benefits.

13.8.3. Duration of Continued or Reinstated Benefits

If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

13.8.3.1. The member withdraws the appeal.

13.8.3.2. Ten (10) days pass after the MCO mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached.

13.8.3.3. A State Fair Hearing Officer issues a hearing decision adverse to the member.

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

13.8.4. Member Responsibility for Services Furnished While the Appeal is Pending

If the final resolution of the appeal is adverse to the member, that is, upholds the MCO's action, the MCO may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this Section, and in accordance with the policy set forth in 42 CFR §431.230(b).

13.9. Information to Providers and Contractors

The MCO must provide the information specified at 42 CFR. §438.10(g)(1) about the grievance system to all providers and contractors at the time they enter into a contract.

13.10. Recordkeeping and Reporting Requirements

Reports of grievances and resolutions shall be submitted to DHH as specified in Section 13.4 of this RFP. The MCO shall not modify the grievance procedure without the prior written approval of DHH.

13.11. Effectuation of Reversed Appeal Resolutions

13.11.1. Services not Furnished While the Appeal is Pending

If the MCO or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires.

13.11.2. Services Furnished While the Appeal is Pending

If the MCO or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO must pay for those services, in accordance with this Contract.

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14.0 QUALITY MANAGEMENT

14.1 Quality Assessment and Performance Improvement Program (QAPI)

14.1.1 The MCO shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program, as required by 42 CFR §438.240(a)(1), to:

14.1.2 Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities;

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

- performance improvement projects;
- medical record audits;
- performance measures;
- Plan-Do-Study-Act cycles or continuous quality improvement activities;
- member and/or provider surveys; and
- activities that address health disparities identified through data collection.

14.1.4 Detect and address underutilization and overutilization of services.

14.1.5 The MCO shall establish a quality improvement strategy which includes at least three (3) non-medically indicated procedures for either prior authorization or nonpayment in specific populations. Multiple medical specialty recommendations on appropriate utilization of services can be found at www.choosingwisely.org/. The strategy will be reviewed and approved by DHH prior to initial implementation and prior to implementation of significant changes, defined as adding or deleting a procedure, to the strategy.

14.1.6 The MCO shall reduce underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long acting reversible contraceptives, ~~and~~ appropriate pain management approaches in patients with sickle cell disease, and behavioral therapy for ADHD and other disorders for children under age 6.

14.1.7 The MCO shall reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than six~~seven~~ years of age.

14.1.8 The MCO shall assess the quality and appropriateness of care furnished to enrollees with special health care needs.

14.1.9 The MCO shall ~~collect and report on CMS electronic Clinical Quality Measures for all contracted providers participating in the Medicaid EHRHER Incentive Payment Program~~promote the Louisiana Medicaid Electronic Health Records (EHR) Incentive Payment Program to further expand adoption and support contracted participating providers through provider education in the collection and reporting on CMS electronic Clinical Quality Measures.

14.1.10 The MCO shall collect data on race, ethnicity, primary language, disability, and geography (i.e., urban/rural). As part of the QAPI program description the MCO shall include the methodology utilized for collecting the data, as well as any interventions taken to enhance the accuracy of the data collected. The MCO shall have the ability to report all performance measures stratified by race, ethnicity, primary language, disability, and geography at the request of DHH.

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

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

14.1.13 The MCO shall submit its QAPI Program description to DHH for written approval by June 30, 2015, and any updates within thirty (30) days.

14.1.14 The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the MCO's governing body shall include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the MCO.

14.1.15 The MCO shall have sufficient mechanisms in place to solicit feedback and recommendations from key stakeholders, members and their families/caregivers, and providers and use feedback and recommendations to improve performance.

14.1.16 The MCO shall disseminate information about findings and improvement actions taken and their effectiveness to DHH and other key stakeholders as directed by DHH.

14.1.17 The MCO shall increase the alignment of assessment and treatment with best practice standards through policies including increasing the use of evidence-based behavioral therapies as the first-line treatment for ADHD for children younger than six years of age, and other methods to increase the alignment with best practices for ADHD care for all children and particularly for children under age six.

14.1.18 The MCO shall conduct peer review to evaluate the clinical competence and quality and appropriateness of care/services provided to members.

14.1.19 The MCO shall participate in the DHH Interdepartmental Monitoring Team (IMT) meetings and other quality improvement-related meetings/workgroups, as directed by DHH.

14.1.20 The MCO shall report the percentage of members who are receiving behavioral health services whose clinical functioning is assessed over time (via clinician and/or member/family ratings on standardized tools, and/or measurable functional outcomes) to measure positive outcomes of service delivered. At a minimum, this will include children receiving CSoC services and EBPs.

14.1.20.1 For members for whom outcomes are assessed, the MCO shall report on the number and percentage of members who show improved functioning with treatment, as well as the amount of improvement.

14.1.20.2 In addition, the MCO shall develop a strategy to increase the use of outcome measurements for all members receiving specialized behavioral health services; the strategy will be due to DHH-OBH on an annual basis.

14.2 QAPI Committee

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

14.2.1 QAPI Committee Members

14.2.1.1 The MCO Medical Director must serve as either the chairman or co-chairman;

14.2.1.2 The MCO Behavioral Health Director;

14.2.1.3 Appropriate MCO staff representing the various departments of the organization will have membership on the committee;

14.2.1.4 The MCO is encouraged to include a member advocate representative on the QAPI Committee; and

14.2.1.5 The MCO shall include ~~a~~ DHH representative(s) on the QAPI Committee, as designated by DHH, as non-voting member(s).~~.~~

14.2.2 QAPI Committee Responsibilities

The committee shall meet on a quarterly basis.~~.~~ Its responsibilities shall include:

14.2.2.1 Direct and review quality improvement (QI) activities;

14.2.2.2 Assure than QAPI activities take place throughout the MCO;

14.2.2.3 Review and suggest new and/or improved QI activities;

14.2.2.4 Direct task forces/committees to review areas of concern in the provision of healthcare services to members;

14.2.2.5 Designate evaluation and study design procedures;

14.2.2.6 Conduct individual PCP and LMHP and practice quality performance measure profiling;

14.2.2.7 Report findings to appropriate executive authority, staff, and departments within the MCO;

14.2.2.8 Direct and analyze periodic reviews of members' service utilization patterns;

14.2.2.9 Maintain minutes of all committee and sub-committee meetings and submit meeting minutes to DHH;

14.2.2.10 Report an evaluation of the impact and effectiveness of the QAPI program to DHH annually. This report shall include, but is not limited to, all care management services;

14.2.2.11 Ensure that the QAPI committee chair attends DHH's quality meetings; and

14.2.2.12 Update provider manuals and other relevant clinical content on a periodic basis as determined by the committee chairperson.

14.2.3 QAPI Work Plan

The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to DHH thirty (30) days after the effective date of the contract and annually thereafter, and prior to implementation of revisions. The QAPI plan, at a minimum, shall:

14.2.3.1 Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;

14.2.3.2 Include processes to evaluate the impact and effectiveness of the QAPI Program;

14.2.3.3 Include a description of the MCO staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities;

14.2.3.4 Describe the role of its providers in giving input to the QAPI Program; and

14.2.3.5 Be exclusive to Louisiana Medicaid and shall not contain documentation from other state Medicaid programs or product lines operated by the MCO.

14.2.3.6 Describe the methods for ensuring data collected and reported to DHH is valid, accurate, and reflects providers' adherence to clinical practice guidelines as appropriate.

14.2.3.7 Include a fidelity monitoring plan which at a minimum includes the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods.

14.2.4 QAPI Reporting Requirements

14.2.4.1 The MCO shall submit QAPI reports annually to DHH which, at a minimum, shall include:

- Quality improvement (QI) activities;
- Recommended new and/or improved QI activities; and

- Results of the evaluation of the impact and effectiveness of the QAPI program.

14.2.4.2 DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.

14.2.4.3 The MCO shall provide data reports, including but not limited to ad-hoc reports and reports for special populations (e.g., DCFS/OJJ, nursing home populations), to DHH using the specifications and format approved by DHH. The MCO shall submit the reports based on the agreed upon dates established by the MCO and DHH.

14.2.5 Performance Measures

14.2.5.1 The MCO shall report clinical and administrative performance measure (PM) data on an annual basis, as specified by DHH and in accordance with the specifications of the ***MCO Quality Companion Guide*** ***and the Behavioral Health Companion Guide.*** ~~.~~

14.2.5.2 The MCO is required to report on Performance Measures listed in Appendix J and Reporting Companion Guide which include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality Review (AHRQ) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, CMS Children's Health Insurance Program Reauthorization ACT (CHIPRA) Children's Core Quality Measures, CMS Adult Core Quality Measures, and/or other measures as determined by DHH.

14.2.5.3 The MCO shall have processes in place to monitor and self-report all performance measures.

14.2.5.4 Clinical PM outcomes shall be submitted to DHH annually and upon DHH request.

14.2.5.5 Administrative PMs shall be submitted to DHH semi-annually and upon DHH request.

14.2.5.6 The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.

14.2.5.7 The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.

14.2.5.8 The tools and reports shall be flexible and adaptable to changes in the quality measurements required by DHH.

~~14.2.5.7~~14.2.5.9 Incentive Based Performance Measures

~~14.2.5.7.1~~14.2.5.9.1 Incentive Based (IB) measures are measures that may affect PMPM payments and can be identified in Appendix J annotated with "$$".

~~14.2.5.7.2~~14.2.5.9.2 Based on an MCO's Performance Measure outcomes for CYE 12/31/2015, a maximum of $~~22~~,~~250~~00,000 ($250,000 per measure) in October following the measurement CY will be withheld from payment if specified performance measures fall below DHH's established benchmarks for improvement.

~~14.2.5.8~~14.2.5.10 DHH expressly reserves the right to modify existing performance IB measures. Any changes in the Incentive Based performance measures will require an amendment to the Contract and DHH will provide six (6) months' notice of such change.

~~14.2.5.9~~14.2.5.11 **Performance Measures Reporting**

~~14.2.5.9.1~~14.2.5.11.1 All measures contained in Appendix J **MCO Performance Measures** and the Behavioral Health Companion Guide are reporting measures.

~~14.2.5.9.2~~14.2.5.11.2 Performance measures shall be reported to DHH in an electronic format as specified in Section 18.10 and Appendix J.

~~14.2.5.9.3~~14.2.5.11.3 DHH may add or remove Performance Measure reporting requirements with a sixty (60) day advance notice.

14.2.5.11.4 The MCO shall report on performance measures in accordance with the current specifications developed by the measure steward and/or approved by DHH.

14.2.5.11.5 The MCO shall utilize the file naming convention established by DHH for all specialized behavioral health report submissions and re-submissions.

14.2.5.11.6 The MCO shall maintain data integrity, accuracy, and consistency in data. As such, all reports submitted to DHH shall include analytical methodology (e.g., numerator, denominator, sampling methodology, data source, data validation methods, results summary, and source code in a statistical language matching one used by DHH). DHH holds the right to validate all reporting for specialized behavioral health measure performance monitoring.

~~14.2.5.10~~14.2.5.12 **Performance Measure Goals**

~~14.2.5.10.1~~14.2.5.12.1 The Department will establish benchmarks for IB Performance measures utilizing the prior year statewide data for the Bayou Health population.

~~14.2.5.10.2~~14.2.5.12.2 Minimum performance goals shall be presented at the first Bayou Health Quality Committee meeting following the contract award date.

~~14.2.5.10.3~~14.2.5.12.3 DHH shall have the authority to establish final performance measure goals after consultation with the Bayou Health Quality Committee. Final determination of goals is at the sole discretion and approval of DHH.

~~14.2.5.11~~14.2.5.13 **Performance Measure Reporting**

~~14.2.5.11.1~~14.2.5.13.1 The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.

~~14.2.5.11.2~~14.2.5.13.2 The tools and reports will be flexible and adaptable to changes in the quality measurements required by DHH.

~~14.2.5.11.3~~14.2.5.13.3 The MCO shall have processes in place to monitor and self-report performance measures as specified in Section 14.3.3 Reporting Measures.

~~14.2.5.11.4~~14.2.5.13.4 The MCO shall provide individual PCP clinical quality profile reports as indicated in Section 8.7 PCP Utilization and Quality Reporting.

14.2.6 Performance Measure Monitoring

14.2.6.1 DHH will monitor the MCO's performance using Benchmark Performance and Improvement Performance data obtained from administrative encounter data submitted by the MCO to the state's FI.

14.2.6.2 During the course of the Contract, DHH or its designee will actively participate with the MCO to review the results of performance measures.

14.2.6.3 The MCO shall comply with External Quality Review Organization's requests for information, including but not limited to a review of the Quality Assessment Committee meeting minutes and annual medical record audits to ensure that it provides quality and accessible health care to MCO members, in accordance with standards contained in the Contract. Such audits shall allow DHH or its duly authorized representative to review individual medical records, identify and collect management data, including but not limited to, surveys and other information concerning the use of services and the reasons for member disenrollment.

14.2.6.4 The standards by which the MCO will be surveyed and evaluated will be at the sole discretion and approval of DHH. If deficiencies are identified, the MCO must formulate a Corrective Action Plan (CAP) incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. DHH must prior approve the CAP and will monitor the MCO's progress in correcting the deficiencies.

14.2.7 Performance Measure Corrective Action Plan

A corrective action plan (CAP) will be required for performance measures that do not reach the Department's performance benchmark.

14.2.7.1 The MCO shall submit a CAP, within thirty (30) calendar days of the date of notification or as specified by DHH, for the deficiencies identified by DHH.

14.2.7.2 Within thirty (30) calendar days of receiving the CAP, DHH will either approve or disapprove the CAP. If disapproved, the MCO shall resubmit, within fourteen (14) calendar days, a new CAP that addresses the deficiencies identified by DHH. If the second CAP does not meet DHH and EQRO approval, DHH may impose liquidated damages, sanctions, and/or restrict enrollment pending attainment of acceptable quality of care.

14.2.7.3 Upon approval of the CAP, whether the initial CAP or the revised CAP, the MCO shall implement the CAP within the time frames specified by DHH.

14.2.7.4 DHH may impose liquidated damages, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.

14.2.8 Performance Improvement Projects

14.2.8.1 The MCO shall establish and implement an ongoing program of Performance Improvement Projects (PIP) that focuses on clinical and non-clinical performance measures as specified in 42 CFR §438.240.

14.2.8.2 The MCO shall perform two (2) DHH-approved PIPs listed in Appendix DD – Performance Improvement Projects –for the initial three-year term of the contract. DHH may require up to two (2) additional projects for a maximum of four (4) projects.

~~14.2.8.1.1~~14.2.8.2.1 Effective 2/1/16, the MCO shall perform a minimum of one (1) additional DHH-approved behavioral-health PIP each contract year.

~~14.2.8.2~~14.2.8.3 Performance Improvement Projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction. Each project must involve the following:

- Measurement of performance using objective quality indicators;
- Implementation of system interventions to achieve improvement in quality;
- Evaluation of the effectiveness of the interventions; and
- Planning and initiation of activities for increasing or sustaining improvement.

~~14.2.8.3~~14.2.8.4 Within three (3) months of the execution of the Contract and at the beginning of each Contract year thereafter, the MCO shall submit, in writing, a general and a detailed description of each Performance Improvement Project to DHH for approval. The detailed description shall include:

- An overview explaining how and why the project was selected, as well as its relevance to the MCO members and providers;
- The study question;

- The study population;
- The quantifiable measures to be used, including the baseline and goal for improvement;
- Baseline methodology;
- Data sources;
- Data collection methodology and plan;
- Data collection plan and cycle, which must be at least monthly;
- Results with quantifiable measures;
- Analysis with time period and the measures covered;
- Explanation of the methods to identify opportunities for improvement; and
- An explanation of the initial interventions to be taken.

~~14.2.8.4~~14.2.8.5 PIPs used to measure performance improvement shall include diagrams (*e.g.* algorithms and/or flow charts) for monitoring and shall:

- Target specific conditions and specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation;
- Use clinical care standards and/or practice guidelines to objectively evaluate the care the MCO delivers or fails to deliver for the targeted clinical conditions;
- Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered;
- Implement system interventions to achieve improvement in quality, including a (PDSA) cycle;
- Evaluate the effectiveness of the interventions;
- Provide sufficient information to plan and initiate activities for increasing or sustaining improvement;
- Monitor the quality and appropriateness of care furnished to enrollees with special health care needs;
- Reflect the population served in terms of age groups, disease categories, and special risk status,
- Ensure that multi-disciplinary teams will address system issues;

- Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal benchmark;

- Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis, and

- Maintain a system for tracking issues over time to ensure that actions for improvement are effective.

~~14.2.8.5~~14.2.8.6 DHH, in consultation with CMS and other stakeholders, may require specific performance measures and topics for performance improvement projects. The MCO shall report the status and results of each Performance Improvement Project as specified in the **MCO Quality Companion Guide** .

~~14.2.8.6~~14.2.8.7 If CMS specifies a Performance Improvement Project, the MCO will participate and this will count toward the state-approved projects.

~~14.2.8.7~~14.2.8.8 Each project shall be completed in a reasonable time period so as to generally allow information on the success of Performance Improvement Projects in the aggregate to produce new information on quality of care every year.

14.2.9 Performance Improvement Projects Reporting Requirements

14.2.9.1 The MCO shall submit to DHH project data analysis monthly or as determined by DHH ~~to DHH.~~

14.2.9.2 The MCO shall submit project outcomes annually to DHH.

14.2.9.3 Reporting specifications are detailed in the ***MCO Quality Companion Guide*** .

14.2.9.4 DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than thirty (30) days prior to due date of those reports.

14.2.10 Member Satisfaction Surveys

14.2.10.1 The MCO shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members.

14.2.10.2 The MCO shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys.

14.2.10.3 The MCO's vendor shall perform CAHPS Adult surveys, CAHPS Child surveys, and CAHPS Children with Chronic Conditions survey.

14.2.10.4 Survey results and a description of the survey process shall be reported to DHH separately for each required CAHPS survey. CAHPS survey results are due with all other performance measures.

14.2.10.5 The CAHPS survey results shall be reported to DHH or its designee for each survey question. These results may be used by DHH for public reporting. Responses will be aggregated by DHH or its designee for reporting. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the MCO at the time of the survey.

14.2.10.6 The surveys shall provide valid and reliable data for results.

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

14.2.10.8 The most current CAHPS Health Plan Survey (currently 5.0) for Medicaid Enrollees shall be used and include:

14.2.10.8.1 Getting Needed Care

14.2.10.8.2 Getting Care Quickly

14.2.10.8.3 How Well Doctors Communicate

14.2.10.8.4 Health Plan Customer Service

14.2.10.8.5 Global Ratings

14.2.10.9 The MCO's vendor shall perform a DHH-approved behavioral health survey to be standardized across the MCOs. The survey results shall be reported to DHH on an annual basis.

14.2.11 DHH Oversight of Quality

14.2.11.1 DHH shall evaluate the MCO's QAPI, PMs, and PIPs at least one (1) time per year at dates to be determined by DHH, or as otherwise specified by the Contract.

14.2.11.2 If DHH determines that the MCO's quality performance is not acceptable, DHH will require the MCO to submit a corrective action plan (CAP) for each unacceptable performance measure. If the MCO fails to provide a CAP within the time specified, DHH will sanction the MCO in accordance with the provisions of sanctions set forth in the Contract, and may immediately terminate all new enrollment activities and automatic assignments.

14.2.11.3 Upon any indication that the MCO's quality performance is not acceptable, DHH may restrict the MCO's enrollment activities including, but not limited to, termination of automatic assignments.

14.2.11.4 When considering whether to impose a limitation on enrollment activities or automatic assignments, DHH may take into account the MCO's cumulative performance on all quality improvement activities.

14.2.11.5 The MCO shall cooperate with DHH, the independent evaluation contractor (External Quality Review Organization), the University of Louisiana at Monroe's Office of Outcomes Research and Evaluation, and any other Department designees during monitoring.

14.3 External Independent Review

14.3.1 The MCO shall provide all information requested by the External Quality Review Organization (EQRO) and/or DHH including, but not limited to, quality outcomes concerning timeliness of, and member access to, core benefits and services.

14.3.2 The MCO shall cooperate with the EQRO during the review (including medical records review), which will be done at least one (1) time per contract year. 2015 annual compliance review results shall be made publically available before March 31, 2016.

14.3.3 If the EQRO indicates that the quality of care is not within acceptable limits set forth in the Contract, DHH may sanction the MCO in accordance with the **provisions** of Section 20 of the Contract and may immediately terminate all enrollment activities and automatic assignment until the MCO attains a satisfactory level of quality of care as determined by the EQRO.

14.3.4 A description of the performance improvement goals, objectives, and activities **developed** and implemented in response to the EQRO findings will be included in the MCO's QAPI program. DHH may also require separate submission of an improvement plan specific to the findings of the EQRO.

14.4 Health Plan Accreditation

14.4.1 The MCO must attain health plan accreditation by NCQA. If the MCO is not currently accredited by NCQA, the MCO must attain accreditation by meeting NCQA accreditation standards.

14.4.2 The MCO's application for accreditation must be submitted at the earliest point allowed by the organization. The MCO must provide DHH with a copy of all correspondence with NCQA regarding the application process and the accreditation requirements.

14.4.3 Achievement of provisional accreditation status shall require a CAP within thirty (30) calendar days of receipt of the Final Report from NCQA. Failure to obtain full NCQA accreditation and to maintain the accreditation thereafter shall be considered a breach of the Contract and shall result in termination of the Contract.

~~Credentialing and Re-credentialing of Providers and Clinical Staff~~

~~The MCO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230, §455.103 and §455.105, and NCQA health plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers.~~

~~The MCO shall use the **Louisiana Standardized Credentialing Application Form** (Appendix F) or Council for Affordable Quality Healthcare (CAQH) standardized credentialing form. These procedures shall be submitted as part of the Proposal, when a change is made, and annually thereafter.~~

~~14.4.4~~ ~~The MCO shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.~~

~~If the MCO has NCQA health plan Accreditation those credentialing policies and procedures shall meet DHH's credentialing requirements.~~

~~) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. "Completely process" shall mean that the MCO shall:~~

~~Review, approve and load approved applicants to its provider files in its claims processing system; and~~

~~Submit on the weekly electronic Provider Directory to DHH or DHH's designee; or~~

~~Deny the application and assure that the provider is not used by the MCO.~~

~~If the MCO has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the contract. The MCO must require that the subcontractor provide assurance that all licensed medical professionals are credentialed in accordance with DHH's credentialing requirements. DHH will have final approval of the delegated entity.~~

~~To the extent the MCO has delegated credentialing agreements in place with any approved delegated credentialing agency, the MCO shall ensure all providers submitted to the MCO from the delegated credentialing agent is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.~~

~~The MCO shall notify DHH when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.~~

~~The process of periodic re-credentialing shall be implemented at least once every three (3) years.~~

~~The MCO shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with the Contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.~~

~~The MCO shall develop and implement a mechanism, subject to DHH approval, for reporting quality deficiencies which result in suspension or termination of a network~~

~~provider/subcontractor(s). This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.~~

~~The MCO shall develop and implement a provider dispute and appeal process, with DHH's approval, for sanctions, suspensions, and terminations imposed by the MCO against network provider/contractor(s) as specified in the Contract. This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.~~

~~**9.12.1.**~~

~~**9.12.2.** The State reserves the right to contract with a single Credential Verification Organization (CVO). If this option is pursued, MCOs and their subcontractors shall agree to use the CVO for the credentialing and recredentialing of all participating providers. The MCO will be given at least 90 days' notice before implementation of any CVO contract.~~

~~**9.12.3.**~~

~~**9.12.4.**~~

~~Credentialing Committee~~

~~**14.4.5** The MCO must designate a credentialing committee that uses a peer review process to evaluate provider credentialing files (including re-credentialing files). The credentialing committee, including the Medical Director, is responsible for credentialing decisions and is required to document its steps in the decision process and maintain individual provider files. A phsician must oversee the credentialing committee.~~

14.5 Member Advisory Council

14.5.1 The MCO shall establish a Member Advisory Council to promote collaborative effort to enhance the service delivery system in local communities while maintaining member focus and allow participation in providing input on policy and programs.

14.5.2 The Council is to be chaired by the MCO's Administrator/CEO/COO or designee and will meet at least quarterly.

14.5.3 Every effort shall be made to include statewide broad representation of both members/families/significant others, member advocacy groups and providers that reflect the population and community served. At least one family member/caregiver of a child with special health care needs shall have representation on the committee. Members/families/significant others and member advocacy groups shall make up at least fifty percent (50%) of the membership.

14.5.4 The MCO shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.

14.5.5 The MCO shall develop and implement a Member Advisory Council Plan that outlines the schedule of meetings and the draft goals for the council that includes, but is not limited to, member's perspectives to improve quality of care. This plan shall be submitted to DHH within thirty (30) days of signing the Contract and annually thereafter.

14.5.6 DHH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally, all agenda and Council minutes shall be posted to the MCO website in English and Spanish, with any member-identifying information redacted.

14.6 Fidelity to Evidence-Based Practices

The MCO will establish a fidelity-monitoring plan in place for Evidenced Based Practice providers to ensure providers' adherence to evidence-based and evidence-informed practices to ensure the core elements of the intervention are maintained and minimum fidelity standards are met. The providers maintain fidelity monitoring for Family Functional Therapy (FFT), Multisystemic Therapy (MST), and Homebuilders as part of the certification/credentialing process. The MCO will maintain Memorandums of Understanding (MOUs) with the fidelity monitoring agencies for Family Functional Therapy, Multisystemic Therapy, and Homebuilders. The MOUs outline a collaborative protocol between the MCO and the monitoring agencies to ensure the appropriate exchange of fidelity reports and other quality reports. The MCO will manage the fidelity monitoring process for Assertive Community Treatment (ACT) providers to ensure minimum fidelity standards are met. A formal fidelity-monitoring plan will be submitted to the State within 30 days of the beginning of the contract, which includes at a minimum the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods. The monitoring system shall include a formalized monitoring review process of all providers' performance on an ongoing basis including a procedure for formal review with site-visits. Site visits shall be conducted according to a periodic schedule individualized by provider type determined by the MCO and approved by DHH. These shall take into account the monitoring responsibilities and efforts of the state agencies. Reports will be submitted quarterly to DHH.

14.7 Best Practices in Children's Behavioral Health Residential Treatment

The MCOs will support initiatives aimed at increased alignment of children's behavioral health residential programming with national best practice standards. The MCO shall participate in planning and implementation of these initiatives with OBH, and collaborate to develop an implementation monitoring plan and provide assistance to providers in collecting and reporting on best practice-related performance indicators (performance indicators may include reducing restraints and seclusions, increased employment of peer professionals, increased family involvement, and 6-12 month post-discharge outcomes data regarding successful integration into the home and community).

14.8 Adverse Incident Reporting

The MCO shall develop, submit, and implement a critical reporting and management procedures for the behavioral health population, subject to review and approval by DHH. The procedure shall describe how the MCO will detect, report, remediate (when applicable), and work to prevent the future re-occurrence of incidents.

The MCO, as directed by DHH, may be required to utilize a third party incident management system in lieu of, or in addition to, its own incident management reporting system. Connection to this third party system is at the cost of the MCO. It shall be the

MCO's decision to replace its own incident management system with the requested third party system or to utilize both systems for incident management.

The MCO shall submit reports to DHH concerning quality of care concerns and adverse incidents, as documented in the Behavioral Health Companion Guide.

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15.0 FRAUD, ABUSE, AND WASTE PREVENTION

15.1. General Requirements

15.1.1. The MCO and its subcontractors shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR §438.1-438.812 and La.R.S. 46:437.1-437.14; LAC 50:I.4101-4235.

15.1.2. The MCO's Program Integrity Officer and CEO or COO shall meet with DHH and the state's Office of Attorney General Medicaid Fraud Control Unit (MFCU) quarterly, annually, and at DHH's request, to discuss fraud, abuse, waste, neglect and overpayment issues. For purposes of this Section, the MCO's Program Integrity Officer shall serve as the primary point of contact for the MCO on issues related to Fraud, Abuse, and Waste Prevention.

15.1.3. The MCO 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, HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, DHH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of six (6) years from the expiration date of the Contract (including any extensions to the Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the Contract and any other applicable rules.

15.1.4. The MCO and its subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The MCO shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

15.1.5. MCO's employees and its contractors and their employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.

15.1.6. The MCO and its subcontractors shall provide access to DHH and/or its designee to all information related to grievances and appeals files by its members. DHH shall monitor enrollment and termination practices and ensure proper implementation of the MCO's grievance procedures, in compliance with 42 CFR §438.226-228.

15.1.7. The MCO shall certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The MCO shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, the Contract, and DHH policy.

15.1.8. The MCO will report to DHH, within three (3) business days, when it is discovered that any MCO employee(s), network provider, contractor, or contractor's employee(s) have been excluded, suspended, or debarred from any state or federal healthcare benefit program ~~through~~ to their ~~following url: http://new.dhh.louisiana.gov/index.cfm/page/219 or DHH prior approved method~~designated Program Integrity contact.

15.1.9. The MCO shall have surveillance and utilization control programs and procedures (42 CFR §456.3, §456.4, §456.23) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The MCO shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities.

15.1.10. The MCO, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.

15.1.11. The MCO, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 C.F.R. §1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and System for Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the MCO dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

15.1.12. The MCO shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the MCO in preventing and detecting potential fraud, waste, and abuse. At a minimum the MCO shall have one (1) full-time investigator physically located within Louisiana for every 100,000 members or fraction thereof. This full-time position(s) is/are in addition to the Program Integrity Officer and must be located in-state.

15.1.13. The MCO is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:

15.1.13.1. The improperly paid funds have already been recovered by the State of Louisiana, either by Louisiana Medicaid directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to false claims act cases; or

15.1.13.2. The improperly paid funds have already been recovered by the State's Recovery Audit Contractor (RAC) contractor; or

15.1.13.3. When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Louisiana, are the subject of pending Federal or State litigation or investigation, or are being audited by the Louisiana RAC.

15.1.14. This prohibition described above in Section 15.1.13 shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. The MCO shall confer with DHH before initiating any recoupment or withhold of any program integrity related funds. (See Section 15.7) to ensure that the recovery recoupment or withhold is permissible. In the event that the MCO obtains funds in cases where recovery recoupment or withhold is prohibited under this Section, the MCO will return the funds to DHH.

15.1.15. The MCO shall comply with all federal and state requirements regarding fraud waste, and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.

15.1.16. Reporting and Investigating Suspected Fraud and Abuse

15.1.16.1. The MCO shall cooperate with all appropriate state and federal agencies, including MFCU, in investigating fraud and abuse.

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

15.1.16.3. The MCO shall notify MFCU and DHH simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to Louisiana Medicaid providers' billing anomalies and/or to safety of Medicaid enrollees that results in a full investigation (42 CFR §455.15). Along with a notification, the MCO shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to MFCU and DHH when the concerns and/or allegations of any tips are authenticated.

15.1.16.4. The MCO shall report all tips, confirmed or suspected fraud, waste and abuse to DHH and the appropriate agency as follows:

15.1.16.4.1. All tips (any program integrity case opened within the previous two (2) weeks) shall be reported to DHH and MFCU;

15.1.16.4.2. Suspected fraud and abuse in the administration of the program shall be reported to DHH and MFCU;

15.1.16.4.3. All confirmed or suspected provider fraud and abuse shall immediately be reported to DHH and MFCU; and

15.1.16.4.4. All confirmed or suspected enrollee fraud and abuse shall be reported immediately to DHH and local law enforcement.

15.1.16.5. The MCO shall utilize a Fraud Reporting Form deemed satisfactory by the agency to whom the report is to be made under the terms of this Contract.

15.1.16.6. The MCO shall be subject to a civil penalty, to be imposed by the DHH, for willful failure to report fraud and abuse by recipients, enrollees, applicants, or providers to DHH MFCU, as appropriate.

15.1.16.7. The MCO shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the MCO shall not take any of the following actions as they specifically relate to Medicaid claims:

15.1.16.7.1. Contact the subject of the investigation about any matters related to the investigation

15.1.16.7.2. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

15.1.16.7.3. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

15.1.16.8. The MCO shall promptly provide the results of its preliminary investigation to DHH or the agency to whom the incident was reported, or to another agency designated by the agency that received the report.

15.1.16.9. The MCO shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview MCO employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.

~~**15.1.16.9.**~~**15.1.16.10.** The MCO is to suspend payment to a network provider when the state determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. The MCO is responsible for sending the network provider the required notice and appeal rights as required by the code of federal regulation.

15.1.17. The State shall not transfer its law enforcement functions to the MCO.

15.1.18. The MCO, subcontractor and providers, whether contract or non-contract, shall, upon request and as required by this Contract or state and/or federal law, make

available to the MFCU any and all administrative, financial and medical records relating to the delivery of items or services for which Louisiana Medicaid monies are expended. Such records will be made available at no cost to the requesting agency. In addition, the MFCU shall, as required by this Contract or state and/or federal law, be allowed access to the place of business and to all Medicaid records of any contractor, subcontractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the MFCU.

15.1.19. The MCO and/or subcontractors shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with this Section, Section 15 of this Contract.

15.1.20. The MCO shall notify DHH when the MCO denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

15.1.21. Except as described in Section 15 of this Contract, nothing herein shall require the MCO to ensure non-contract providers are compliant with Louisiana Medicaid contracts or state and/or federal law.

15.1.22. In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, the MCO shall report overpayments made by DHH to the MCO as well as overpayments made by the MCO to a provider and/or subcontractor.

15.1.23. The MCO shall have at least one (1) full-time investigator or full-time equivalent per 100,000 enrollees or fraction thereof. This full-time position(s) is/are in addition to the Program Integrity Officer and must be located in-state.

15.2. Fraud, Waste, and Abuse Compliance Plan

15.2.1. In accordance with 42 CFR §438.608(a), the MCO shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud, Waste, and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.

15.2.2. In accordance with 42 CFR §438.608(b)(2), the MCO shall designate a Program Integrity Officer and Program Integrity committee that have the responsibility and authority for carrying out the provisions of the compliance program. These individuals shall be accountable to the MCO's board of directors and shall be directly answerable to the Executive Director or to the board of directors and senior management. The MCO shall have an adequately staffed Medicaid Program Integrity office with oversight by the Program Integrity Officer.

15.2.3. The MCO shall submit the Fraud, Waste, and Abuse Compliance Plan within thirty (30) days from the date the Contract is signed, annually thereafter, and upon updates or modifications to DHH for approval at least thirty (30) days in advance of making them effective. DHH, at its sole discretion, may require that the MCO modify its compliance plan. The MCO compliance program shall incorporate the policy and procedures as follows:

15.2.3.1. Written policies, procedures, and standards of conduct that articulate MCO's commitment to comply with all applicable federal and state standards;

15.2.3.2. Effective lines of communication between the Program Integrity Officer and the MCO's employees, providers and contractors enforced through well publicized disciplinary guidelines;

15.2.3.3. Procedures for ongoing monitoring and auditing of MCO systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous quality improvement activities, and provider activities;

15.2.3.4. Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the Program Integrity Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;

15.2.3.5. Provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR §438.608(b)(4)-(6);

15.2.3.6. Protections to ensure that no individual who reports program integrity related violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the MCO. The MCO shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible. Anyone who believes that he or she has been retaliated against may report this violation to DHH and/or the U.S. Office of Inspector General;

15.2.3.7. Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract in accordance with 42 CFR §438.608(b)(7);

15.2.3.8. Well-publicized disciplinary procedures that shall apply to employees who violate the MCO compliance program;

15.2.3.9. Effective training and education for the Program Integrity Officer, program integrity investigators, managers, employees, providers and members to ensure that they know and understand the provisions of MCO's compliance plan;

15.2.3.10. Fraud, Waste and Abuse Training shall include, but not be limited to:

- Annual training of all employees;
- New hire training within thirty (30) days of beginning date of employment.

15.2.3.11. MCO will require new employees to complete and attest to training modules within thirty (30) days of hire related to the following in accordance with federal and state laws:

- MCO Code of Conduct Training

- Privacy and Security - Health Insurance Portability and Accountability Act
- Fraud, waste, and abuse
- Procedures for timely consistent exchange of information and collaboration with DHH;
- Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and
- Provisions that comply with 42 CFR §438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' ***Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks***) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.

15.3. Prohibited Affiliations

15.3.1. In accordance with 42 CFR §438.610, the MCO is prohibited from knowingly having a relationship with: An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

15.3.2. The MCO shall comply with all applicable provisions of 42 CFR §438.610 pertaining to debarment and/or suspension. The MCO shall screen all employees and contractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the MCO shall conduct screenings to comply with the requirements re set forth at 42 CFR §455.436.

15.3.3. The MCO shall search the following websites:

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

15.3.4. The MCO shall conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered should be reported to DHH within three (3) business days. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary

penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR §1003.102(a)(2).

15.3.4.1. An individual who is an affiliate of a person described above and include:

- A director, officer, or partner of the MCO;
- A person with beneficial ownership of five (5%) percent or more of the MCO's equity; or
- A person with an employment, consulting or other arrangement with the MCO for the provision of items and services which are significant and material to the MCO's obligations.

15.3.4.2. The MCO shall notify DHH within three (3) days of the time it receives notice that action is being taken against the MCO or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the MCO or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

15.4. Payments to Excluded Providers

15.4.1. Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for emergency services; and

15.4.2. The MCO is responsible for the return of any money paid for services provided by an excluded provider.

15.5. Reporting

15.5.1. In accordance with 42 CFR §455.1(a)(1) and §455.17, the MCO shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the state's Office of Attorney General MFCU, and DHH within three (3) business days of discovery, taking prompt corrective actions and cooperating with DHH in its investigation of the matter(s). Additionally, the MCO shall notify DHH within three (3) business days of the time it receives notice that action is being taken against the MCO or MCO employee, network providers contractor or contractor employee or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the MCO or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

15.5.2. Reporting shall include, but is not limited to, as set forth at 42 CFR §455.17:

15.5.2.1. ~~A.~~ Number of complaints of fraud, abuse, waste, neglect and overpayments made to the MCO that warrant preliminary investigation (defined at 42 CFR §455.14);

15.5.2.2. Number of complaints reported to the Program Integrity Officer; and

15.5.2.3. For each complaint that warrants full investigation (defined at 42 CFR §455.15 and §455.16), the MCO shall provide DHH, at a minimum, the following:

- Provider Name and ID number;
- Source of complaint;
- Type of provider;
- Nature of complaint;
- Approximate range of dollars involved if applicable; and
- Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.

15.5.3. The MCO, through its compliance officer, shall attest monthly to DHH that a search of the websites referenced in Section 15.3.3 has been completed to capture all exclusions.

15.6. Medical Records

15.6.1. The MCO shall have a method to verify that services for which reimbursement was made, was provided to members. The MCO shall have policies and procedures to maintain, or require MCO providers and contractors to maintain, an individual medical record for each member. The MCO shall ensure the medical record is:

15.6.1.1. Accurate and legible;

15.6.1.2. Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or treated, and is accessible for review and audit; and

15.6.1.3. Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.

15.6.2. The MCO shall ensure the medical record includes, minimally, the following:

15.6.2.1. Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);

15.6.2.2. Primary language spoken by the member and any translation needs of the member;

15.6.2.3. Services provided through the MCO, date of service, service site, and name of service provider;

15.6.2.4. Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the MCO;

15.6.2.5. Referrals including follow-up and outcome of referrals;

15.6.2.6. Documentation of emergency and/or after-hours encounters and follow-up;

15.6.2.7. Signed and dated consent forms (as applicable);

15.6.2.8. Documentation of immunization status;

15.6.2.9. Documentation of advance directives, as appropriate;

15.6.2.10. Documentation of each visit must include:

- Date and begin and end times of service;
- Chief complaint or purpose of the visit;
- Diagnoses or medical impression;
- Objective findings;
- Patient assessment findings;
- Studies ordered and results of those studies (*e.g.* laboratory, x-ray, EKG);
- Medications prescribed;
- Health education provided;
- Name and credentials of the provider rendering services (*e.g.* MD, DO, OD) and the signature or initials of the provider; and
- Initials of providers must be identified with correlating signatures.

15.6.2.11. Documentation of EPSDT requirements including but not limited to:

- Comprehensive health history;
- Developmental history;
- Unclothed physical exam;
- Vision, hearing and dental screening;
- Appropriate immunizations;
- Appropriate lab testing including mandatory lead screening; and
- Health education and anticipatory guidance.

15.6.3. The MCO is required to provide one (1) free copy of any part of member's record upon member's request.

15.6.4. All documentation and/or records maintained by the MCO or any and all of its network providers shall be maintained for at least six (6) calendar years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an

administrative or judicial action brought by or on behalf of the state or federal government.

15.7. Rights of Review and Recovery by MCO and DHH

15.7.1. Each MCO is responsible for investigating possible acts of provider fraud, abuse, and waste for all services under this contract, including those services that the MCO subcontracts to outside entities.

15.7.2. The MCO has the exclusive right of review and recovery for 365 days from the original date of service of a claim to initiate a "complex" review of such claim to determine a potential overpayment and/or underpayment, by delivering notice to the provider in writing of initiation of such a review. A "complex" review is one for which the MCO's review of medical, financial and/or other records, including those on-site where necessary to determine the existence of an improper payment.

Notice to the provider shall be prohibited in instances resulting from suspected fraud, which the MCO has identified and referred to the Department, MFCU, or other appropriate law enforcement agency, unless approved by DHH.

15.7.3. All "complex" reviews must be completed within one hundred and twenty (120) days of the date of the notice to the provider unless an extension is authorized by the Department. This review period is inclusive of all provider notification, health plan document review, and including any provider appeal or rebuttal process. The MCO shall notify the Department, at least on a monthly basis, the results of "complex" reviews that include as well as instances of suspected fraud and/or a collection status.

15.7.4. The MCO shall not retain the exclusive right of review and/or recovery beyond 365 days from the original date of service of a claim for a "complex" review, but the MCO may conduct audits of providers' claims for a five (5) year period from the date of service of a claim. Results of the audit reviews must be communicated to the Department at least monthly in instances of suspected fraud or requiring collection. The collected funds from those reviews are to remain with the MCO.

15.7.5. If the MCO does not initiate action through official notification to a provider with respect to a "complex" claim review within 365 days from the original date of service of the claim or fails to collect at least a portion of the "complex" claim~~claom~~ review recovery after 365 days from the date of notice to the Department of the collection status, unless in either scenario an extension is authorized by the Department or its agent may recover from the provider any overpayments which they identify and said recovered funds will be returned to the State.

15.7.6. The MCO shall not retain the exclusive right of review and/or recovery from the initial date of service of a claim for which the Department or its agent identifies improper payment(s) as a result of "automated" claims reviews. An "automated" review is one for which an analysis of the paid claims is sufficient to determine the existence of an improper mispayment(s) where as no additional documentation is required to be submitted from the provider to determine the existence of an overpayment.

15.7.7. DHH may recover from the provider any overpayments which they identify through an "automated" review and said recovered funds will be returned to the State.

15.7.8. DHH must notify the MCO of an identified improper payment from a "complex" or "automated" review prior to notifying any provider(s). The MCO shall have thirty (30) calendar days from the date of notification of potential improper payments(s) to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department or its agent.

15.7.9. The MCO shall not correct the claims nor initiate an audit on the claims upon notification by the Department or its agent unless directed to do so by the Department.

15.7.10. In the event the provider does not refund overpayments identified by the Department or its agent to the State, or arrange for an acceptable payment plan with the State, within thirty (30) calendar days of notification to the provider of the overpayment or where applicable, within thirty (30) calendar days of notification of the conclusion of the appeal process, the Department or its agent will notify the MCO and the MCO shall initiate a payment withhold on the provider in the amount due to the Department. The MCO shall collect and refund any amounts collected to the Department. Any instances of a credit balance would be sustained by the MCO and/or Department until resolved or dismissed under Department rules.

15.7.11. There will be no DHH provider improper payment recovery request of the MCO applicable for the dates of service occurring before the start of the Bayou Health Contract period or for providers for which no MCO relationship existed.

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16.0 SYSTEMS AND TECHNICAL REQUIREMENTS

16.1. General Requirements

16.1.1. The MCO shall maintain an automated Management Information System (MIS), hereafter referred to as System, which accepts and processes provider claims, verifies eligibility, collects and reports encounter data and validates prior authorization and pre-certification that complies with DHH and federal reporting requirements. The MCO shall ensure that its System meets the requirements of the Contract, state issued Guides (***See MCO Encounter Data Companion Guide and OBH Client Level Data Standards and Procedures Manual***) and all applicable state and federal laws, rules and regulations, including Medicaid confidentiality and HIPAA and American Recovery and Reinvestment Act (ARRA) privacy and security requirements.

16.1.2. The MCO application systems foundation shall employ a relational data model in its database architecture, which would entail the utilization of a relational database management system (RDBMS) such as Oracle®, DB2®, or SQL Server®. It is important that the MCO's application systems support query access using Structured Query Language (SQL). Other standard connector technologies, such as Open Database Connectivity (ODBC) and/or Object Linking and Embedding (OLE), are desirable.

16.1.3. All MCO applications, operating software, middleware, and networking hardware and software shall be able to interoperate as needed with DHH's systems and shall conform to applicable standards and specifications set by DHH.

16.1.4. The MCO's System shall have, and maintain, capacity sufficient to handle the workload projected for the begin date of operations and shall be scalable and flexible so that it can be adapted as needed, within negotiated timeframes, in response to changes in the Contract requirements.

16.1.5 The Contractor must be capable of transmitting all non-proprietary data which is relevant for analytical purposes to DHH on a regular schedule in XML format. Final determination of relevant data will be made by DHH based on collaboration between both parties. The schedule for transmission of the data will be established by DHH and dependent on the needs of the Department related to the data being transmitted. XML files for this purpose will be transmitted via Secure File Transfer Protocol (SFTP) to the Department. Any other data or method of transmission used for this purpose must be approved via written agreement by both parties.

16.1.6 Proposer must clearly outline the solution's technical approach as it relates to a service oriented architecture. Details should include a description of capability and potential strategy for integration with future DHH-wide enterprise components as they are established, specifically making use of an enterprise service bus for managing touch points with other systems, integration with a master data management solution and flexibility to utilize a single identity and access management solution.

16.1.7 The contractor is responsible for procuring and maintaining hardware and software resources which are sufficient to successfully perform the services detailed in this RFP.

16.1.8 The contractor should adhere to state and federal regulations and guidelines as well as industry standards and best practices for systems or functions required to support the requirements of this RFP.

16.1.9 The contractor shall clearly identify any systems or portions of systems outlined in the proposal which are considered to be proprietary in nature.

16.1.10 Unless explicitly stated to the contrary, the contractor is responsible for all expenses required to obtain access to DHH systems—including systems maintained by other contractors including but not limited to the Medicaid fiscal intermediary and Medicaid enrollment broker--or resources which are relevant to successful completion of the requirements of this RFP. The contractor is also responsible for expenses required for DHH to obtain access to the Contractor's systems or resources which are relevant to the successful completion of the requirements of this RFP. Such expenses are inclusive of hardware, software, network infrastructure and any licensing costs.

16.1.11 Any confidential information must be encrypted to FIPS 140-2 standards when at rest or in transit.

16.1.12 Contractor owned resources must be compliant with industry standard physical and procedural safeguards (NIST SP 800-114, NIST SP 800-66, NIST 800-53A, ISO 17788, etc.) for confidential information (HITECH, HIPAA part 164).

16.1.13 Any contractor use of flash drives or external hard drives for storage of Medicaid data must first receive written approval from the Department and upon such approval shall adhere to FIPS 140-2 hardware level encryption standards.

16.1.14 All contractor utilized computers and devices must:

16.1.14.1 Be protected by industry standard virus protection software which is automatically updated on a regular schedule;

16.1.14.2 Have installed all security patches which are relevant to the applicable operating system and any other system software; and

16.1.14.3 Have encryption protection enabled at the Operating System level.

16.1.15 The contractor must have:

16.1.15.1 Capabilities of interagency electronic transfer to and from the participating state agencies (DHH-OBH, DCFS, and OJJ) as needed to support the operations as determined by DHH;

16.1.15.2 Electronic storage and retrieval of individualized Plans of Care (POC), treatment plans, crisis plans, and advance directives;

16.1.15.3 An MCO Data Warehouse that supports the timely submission of valid data, including but not limited to encounter data,

16.1.15.4 A secure online web-based portal that allows providers and state agencies (DCFS, LDOE, DHH, and OJJ) to submit and receive responses to referrals and prior authorizations for services;

16.1.15.5 The MIS will regularly (e.g., bi-weekly) electronically transfer client/episode-level recipient, assessment, service, and provider data as directed by DHH for purposes of state and federal reporting (e.g., SAMHSA National Outcome Measures (NOMS), Treatment Episode Data Sets (TEDS), Government Performance Reporting Act (GPRA)), and for ad hoc reporting as needed by the state for service quality monitoring and performance accountability

16.2 HIPAA Standards and Code Sets

16.2.1. The System shall be able to transmit, receive and process data in current HIPAA-compliant or DHH specific formats and/or methods, including, but not limited to, secure File Transfer Protocol (FTP) over a secure connection such as a Virtual Private Network (VPN), that are in use at the start of Systems readiness review activities. Data elements and file format requirements may be found in the MCO Encounter Data Companion Guide.

16.2.2. All HIPAA-conforming exchanges of data between DHH and the MCO shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker. The **HIPAA Business Associate Agreement** (Appendix C) shall become a part of the Contract.

16.2.3. The System shall conform to the following HIPAA-compliant standards for information exchange. Batch transaction types include, but are not limited to, the following:

- ASC X12N 834 Benefit Enrollment and Maintenance;
- ASC X12N 835 Claims Payment Remittance Advice Transaction;
- ASC X12N 837I Institutional Claim/Encounter Transaction;
- ASC X12N 837P Professional Claim/Encounter Transaction;
- ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;
- ASC X12N 276 Claims Status Inquiry;
- ASC X12N 277 Claims Status Response;
- ASC X12N 278Utilization Review Inquiry/Response;
- ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products; and
- NCPDP Pharmacy Claims.

16.2.4. The MCO shall not revise or modify standardized forms or formats.

16.2.5. Transaction types are subject to change and the MCO shall comply with applicable Federal and HIPAA standards and regulations as they occur.

16.2.6. The MCO shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with DHH. These shall include, but not be limited to, HIPAA based standards, Federal safeguard requirements including signature requirements described in the CMS State Medicaid Manual.

16.3 Connectivity

16.3.1 DHH is requiring that the MCO interface with DHH, the Medicaid Fiscal Intermediary (FI), the Enrollment Broker (EB), and its trading partners. The MCO must have capacity for real time connectivity to all DHH approved systems. The MCO must have the capability to allow and enable authorized DHH personnel to have real-time connectivity to the MCO's system as remote connections from DHH offices.

16.3.2 The System shall conform and adhere to the data and document management standards of DHH and its FI, inclusive of standard transaction code sets as outlined in the MCO Systems Companion Guide.

16.3.3. The MCO's Systems shall utilize mailing address standards in accordance with the United States Postal Service.

16.3.4. The MCO shall encourage all hospitals, physicians, and other providers in its network to adopt health information technology (HIT) and its meaningful use, with specific emphasis on connection to the Louisiana Health Information Exchange (LaHIE) and development of a secure, web-accessible health record for members, such as personal health record (PHR). The MCO shall participate in the planning and implementation of a single, all-payer PHR at such time that DHH requires.

16.3.5. The MCO shall require all emergency departments (EDs) in its network to exchange admit discharge transfer (ADT) data with LaHIE's ED visit registry to aid in identification of and creation of policies around high utilizers, drug seeking behavior, and chronic disease management. The visit registry would consist of three basic attributes: 1) the ability to capture and match patients based on demographics information, 2) the ability to identify the facility at which care is being sought, and 3) at minimum, the chief complaint of the visit. These three pieces of information are commonly available through the HL7 ADT message standard and in use by most ED admission systems in use today across the country.

16.3.6. The MCO shall require all network hospitals to comply with the data submission requirements of Louisiana Revised Statues Section 1300.111-114. Including, but not limited to, syndromic surveillance data under the Sanitary Code of the State of Louisiana (LAC 51:II.105). MCOs shall encourage the use of LaHIE where direct connections to public health reporting information systems are not feasible or are cost prohibitive.

16.3.7. All information, whether data or documentation and reports that contain or references to that information involving or arising out of the Contract is owned by DHH. The MCO is expressly prohibited from sharing or publishing DHH's information and reports without the prior written consent of DHH. In the event of

a dispute regarding the sharing or publishing of information and reports, DHH's decision on this matter shall be final.

16.3.8. The Medicaid Management Information System (MMIS) processes claims and payments for covered Medicaid services within the fee-for-service Medicaid program. DHH's current MMIS contract expires December 31, 2015.~~2014.~~ DHH anticipates twelve month extension of the existing FI contract until such time that a reprocurement for Medicaid fiscal intermediary services is completed. DHH will require the MCO to comply with all transitional requirements as necessary should DHH contract with a new FI during the Contract at no cost to DHH or its FI.

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

16.3.10. DHH may require the MCO to complete an Information Systems Capabilities Assessment (ISCA), which will be provided by DHH. The ISCA shall be completed and returned to DHH no later than thirty (30) days from the date the MCO signs the Contract DHH.

16.3.11. Hardware and Software

The MCO must maintain hardware and software compatible with current DHH requirements which are as follows. This includes, but is not limited to, call center operations, claims EDI operations, authorized services operations, and member services operations:

16.3.11.1. Desktop Workstation Hardware:

- IBM-compatible, networked PC running Microsoft Windows 7 or later operating system.

16.3.11.2. Desktop Workstation Software:

- Operating system should be Microsoft Windows 7 or later,
- Web browser that is equal to or surpasses Microsoft Internet Explorer v7.0 and is capable of resolving JavaScript and ActiveX scripts;
- An e-mail application that is compatible with Microsoft Outlook 2007 or later, The e-mail application should have the ability to send secure messages in the case that Protected Health Information (PHI) is present. E-mail users should be periodically (at least annually) trained in the appropriate use of secure e-mail functionality with respect to PHI;
- An office productivity suite such as Microsoft Office that is compatible with Microsoft Office 2007 or later;
- Each workstation should be networked and have access to high speed Internet;
- Each workstation connected to the Internet should have anti-virus, anti-spam, and anti-malware software. Regular and frequent updates of the

virus definitions and security parameters of these software applications should be established and administered;

- A desktop compression/encryption application that is compatible with WinZIP v11.0;

- All contractor-utilized workstations, laptops and portable communication devices shall be:

  - Protected by industry standard virus protection software which is automatically updated on a regular schedule;
  - Have installed all security patches which are relevant to the applicable operating system and any other system software; and
  - Have encryption protection enables at the Operating System level.

- Compliant with industry-standard physical and procedural safeguards for confidential information (NIST 800-53A, ISO 17788, etc.).

16.3.11.3. Network and Back-up Capabilities

- Establish a local area network or networks as needed to connect all appropriate workstation personal desktop computers (PCs);

- Establish appropriate hardware firewalls, routers, and other security measures so that the MCO's computer network is not able to be breached by an external entity;

- Establish appropriate back-up processes that ensure the back-up, archival, and ready retrieval/recovery of mainframe (when applicable), network server data and desktop workstation data;

- Ensure that network hardware is protected from electrical surges, power fluctuations, and power outages by using the appropriate uninterruptible power system (UPS) and surge protection devices; and

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

16.4. Resource Availability and Systems Changes

16.4.1. Resource Availability

The MCO shall provide Systems Help Desk services to DHH, its FI, and Enrollment Broker staff that have direct access to the data in the MCO's Systems.

16.4.1.1. The Systems Help Desk shall:

- Be available via local and toll-free telephone service, and via e-mail from 7a.m. to 7p.m., Central Time, Monday through Friday, with the exception of DHH-designated holidays. Upon request by DHH, the MCO shall be

required to staff the Systems Help Desk on a state holiday, Saturday, or Sunday;

- Answer questions regarding the MCO's System functions and capabilities; report recurring programmatic and operation problems to appropriate staff for follow-up; redirect problems or queries that are not supported by the Systems Help Desk, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate DHH staff;

- Ensure individuals who place calls after hours have the option to leave a message. The MCO's staff shall respond to messages left between the hours of 7p.m. and 7a.m. by noon that next business day;

- Ensure recurring problems not specific to Systems unavailability identified by the Systems Help Desk shall be documented and reported to MCO management within one (1) business day of recognition so that deficiencies are promptly corrected; and

- Have an IS service management system that provides an automated method to record, track and report all questions and/or problems reported to the Systems Help Desk.

16.4.2. Systems Quality Assurance Plan

16.4.2.1. The MCO shall ensure that written Systems process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems. The Systems Quality Assurance Plan information systems documentation requirements must be submitted to DHH for approval no later than thirty (30) days from the date the Contract is signed. At a minimum, the Systems Quality Assurance Plan must address the following:

16.4.2.1.1. The MCO shall develop, prepare, print, maintain, produce, and distribute to DHH distinct Systems design and management manuals, user manuals and quick reference Guides, and any updates.

16.4.2.1.2. The MCO shall ensure the Systems user manuals contain information about, and instruction for, using applicable Systems functions and accessing applicable system data.

16.4.2.1.3. The MCO shall ensure when a System change is subject to DHH prior written approval, the MCO will submit revision to the appropriate manuals before implementing said Systems changes.

16.4.2.1.4. The MCO shall ensure all aforementioned manuals and reference Guides are available in printed form and on-line; and

16.4.2.1.5. The MCO shall update the electronic version of these manuals immediately, and update printed versions within ten (10) business days of the update taking effect.

16.4.2.1.6. The MCO shall provide to DHH documentation describing its Systems Quality Assurance Plan.

16.4.3. Systems Changes

16.4.3.1. The MCO's Systems shall conform to future federal and/or DHH specific standards for encounter data exchange within ninety (90) calendar days prior to the standard's effective date or earlier, as directed by CMS or DHH.

16.4.3.2. If a system update and/or change are necessary, the MCO shall draft appropriate revisions for the documentation or manuals, and present to DHH thirty (30) days prior to implementation, for DHH review and approval. Documentation revisions shall be accomplished electronically and shall be made available for Department review in an easily accessible, near real-time method. Printed manual revisions shall occur within ten (10) business days of the actual revision.

16.4.3.3. The MCO shall notify DHH staff of the following changes to its System within its span of control at least ninety (90) calendar days prior to the projected date of the change:

Major changes, upgrades, modification or updates to application or operating software associated with the following core production System:

- Claims processing;
- Eligibility and enrollment processing;
- Service authorization management;
- Provider enrollment and data management; and
- Conversions of core transaction management Systems.

16.4.3.4. The MCO shall respond to DHH notification of System problems not resulting in System unavailability according to the following timeframes:

- Within five (5) calendar days of receiving notification from DHH, the MCO shall respond in writing to notices of system problems.
- Within fifteen (15) calendar days, the correction shall be made or a requirements analysis and specifications document will be due.
- The MCO shall correct the deficiency by an effective date to be determined by DHH.
- The MCO's Systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.
- The MCO shall put in place procedures and measures for safeguarding against unauthorized modification to the MCO's Systems.

16.4.3.5. Unless otherwise agreed to in advance by DHH, the MCO shall not schedule Systems unavailability to perform system maintenance, repair and/or

upgrade activities to take place during hours that can compromise or prevent critical business operations.

16.4.3.6. The MCO shall work with DHH pertaining to any testing initiative as required by DHH and shall provide sufficient system access to allow testing by DHH and/or its FI of the MCO's System.

16.5. Systems Refresh Plan

16.5.1. The MCO shall provide to DHH an annual Systems Refresh Plan within thirty(30) days from the date the Contract is executed, annually thereafter, and prior to implementation of revisions. The plan shall outline how Systems within the MCO's span of control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors.

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

16.6. Other Electronic Data Exchange

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

16.6.2. The MCO shall implement Optical Character Recognition (OCR) technology that minimizes manual indexing and automates the retrieval of scanned documents.

16.7. Electronic Messaging

16.7.1. The MCO shall provide a continuously available electronic mail communication link (e-mail system) to facilitate communication with DHH. This e-mail system shall be capable of attaching and sending documents created using software compatible with DHH's installed version of Microsoft Office (currently 2007) and any subsequent upgrades as adopted.

16.7.2. As needed, the MCO shall be able to communicate with DHH over a secure Virtual Private Network (VPN).

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

16.8. Eligibility and Enrollment Data Exchange

The MCO shall:

- Receive, process and update enrollment files sent daily by the Enrollment Broker;
- Update its eligibility and enrollment databases within twenty-four (24) hours of receipt of said files;
- Transmit to DHH, in the formats and methods specified by DHH, member address changes and telephone number changes;
- Be capable of uniquely identifying (i.e., Master Patient Index) a distinct Medicaid member across multiple populations and Systems within its span of control; and
- Be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by DHH, resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

16.9. Provider Enrollment

16.9.1. At the onset of the MCO Contract and periodically as changes are necessary, DHH shall furnish to the MCO a list of Louisiana Medicaid provider types, specialty, and sub-specialty codes. In order to coordinate provider enrollment records, the MCO shall utilize the published list of Louisiana Medicaid provider types, specialty, and sub-specialty codes in all provider data communications with DHH and the Enrollment Broker. The MCO shall provide the following:

- A weekly Provider Registry File to include provider name, address, licensing information, Tax ID, National Provider Identifier (NPI), taxonomy, contract information, and other data as detailed in the MCO Systems Companion Guide;
- A weekly Provider Site File as described in the MCO Systems Companion Guide;
- A weekly Primary Care Provider Linkage file as described in the MCO Systems Companion Guide;
- All relevant provider ownership information as prescribed by DHH, federal or state laws; and

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

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

- Audit trail and history of changes made to the provider file;
- Automated interfaces with all licensing and medical boards;
- Automated alerts when provider licenses are nearing expiration;
- Retention of NPI requirements;
- System generated letters to providers when their licenses are nearing expiration;
- Linkages of individual providers to groups;
- Credentialing information;
- Provider office hours; and
- Provider languages spoken.

16.10. Information Systems Availability

The MCO shall:

16.10.1. Not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the MCO's span of control;

16.10.2. Allow DHH personnel, agents of the Louisiana Attorney General's Office or individuals authorized by DHH or the Louisiana Attorney General's Office and upon request by CMS direct access to its data for the purpose of data mining and review;

16.10.3. Ensure that critical member and provider Internet and/or telephone-based IVR functions and information functions are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week except during periods of scheduled System unavailability agreed upon by DHH and the MCO. Unavailability caused by events outside of the MCO's span of control is outside of the scope of this requirement;

16.10.4. Ensure that at a minimum all other System functions and information are available to the applicable system users between the hours of 7a.m. and 7p.m., Central Time, Monday through Friday;

16.10.5. Ensure that the systems and processes within its span of control associated with its data exchanges with DHH's FI and/or Enrollment Broker and its contractors are available and operational;

16.10.6. Ensure that in the event of a declared major failure or disaster, the MCO's core eligibility/enrollment and claims processing system shall be back on line within seventy-two (72) hours of the failure's or disaster's occurrence;

16.10.7. Notify designated DHH staff via phone, fax and/or electronic mail within sixty (60) minutes upon discovery of a problem within or outside the MCO's span of control that may jeopardize or is jeopardizing availability and performance of critical systems functions and the availability of critical information as defined in this Section, including any problems impacting scheduled exchanges of data between the MCO and DHH or DHH's FI. In its notification, the MCO shall explain in detail the impact to critical path processes such as enrollment management and encounter submission processes;

16.10.8. Notify designated DHH staff via phone, fax, and/or electronic mail within fifteen (15) minutes upon discovery of a problem that results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocol;

16.10.9. Provide information on System unavailability events, as well as status updates on problem resolution, to appropriate DHH staff. At a minimum these updates shall be provided on an hourly basis and made available via phone and/or electronic mail;

16.10.10. Resolve and implement system restoration within sixty (60) minutes of official declaration of unscheduled System unavailability of critical functions caused by the failure of system and telecommunications technologies within the MCO's span of control. Unscheduled System unavailability to all other System functions caused by system and telecommunications technologies within the MCO's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability;

16.10.11. Cumulative Systems unavailability caused by systems and/or IS infrastructure technologies within the MCO's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period; and

16.10.12. Within five (5) business days of the occurrence of a problem with system availability, the MCO shall provide DHH with full written documentation that includes a corrective action plan describing how the MCO will prevent the problem from reoccurring.

16.11. Contingency Plan

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

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

including both the DRP and the BCP in the contingency planning process is a best practice.

16.11.3. The MCO shall have a Contingency Plan that must be submitted to DHH for approval no later than thirty (30) days from the date the Contract is signed.

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

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

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

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

16.11.4.4. System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system, but does prevent access to the System, such as it causes unscheduled System unavailability; and

16.11.4.5. The Plan shall specify projected recovery times and data loss for mission-critical Systems in the event of a declared disaster.

16.11.5. The MCO shall annually test its plan through simulated disasters and lower level failures in order to demonstrate to DHH that it can restore Systems functions.

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

16.12. Off Site Storage and Remote Back-up

16.12.1. The MCO shall provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.

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

16.12.2.1. Descriptions of the controls for back-up processing, including how frequently back-ups occur;

16.12.2.2. Documented back-up procedures;

16.12.2.3. The location of data that has been backed up (off-site and on-site, as applicable);

16.12.2.4. Identification and description of what is being backed up as part of the back-up plan; and

16.12.2.5. Any change in back-up procedures in relation to the MCO's technology changes.

16.12.2.6. A list of all back-up files to be stored at remote locations and the frequency with which these files are updated.

16.13. Records Retention

16.13.1. The MCO shall have online retrieval and access to documents and files for six (6) years in live systems for audit and reporting purposes, ten (10) years in archival systems. Services which have a once in a life-time indicator (i.e., appendix removal, hysterectomy) are denoted on DHH's procedure formulary file and claims shall remain in the current/active claims history that is used in claims editing and are not to be archived or purged. Online access to claims processing data shall be by the Medicaid recipient ID, provider ID and/or ICN (internal control number) to include pertinent claims data and claims status. The MCO shall provide forty-eight (48) hour turnaround or better on requests for access to information that is six (6) years old, and seventy-two (72) hour turnaround or better on requests for access to information in machine readable form, that is between six (6) to ten (10) years old. If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

16.13.2. The historical encounter data submission shall be retained for a period not less than six (6) years, following generally accepted retention guidelines.

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

16.14. Information Security and Access Management

The MCO's system shall:

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

16.14.1.1 Establish unique access identification per MCO employee;

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

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

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

16.14.2 Make System information available to duly authorized representatives of DHH and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

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

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

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

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

16.14.4.3 Have the ability to trace data from the final place of recording back to its source data file and/or document;

16.14.4.4 Be supported by listings, transaction reports, update reports, transaction logs, or error logs; and

16.14.4.5 Facilitate auditing of individual records as well as batch audits.

16.14.5 Have inherent functionality that prevents the alteration of finalized records;

16.14.6 Provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The MCO shall provide DHH with access to data facilities upon request. The physical security provisions shall be in effect for the life of the Contract;

16.14.7 Restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access;

16.14.8 Include physical security features designed to safeguard processor sites through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel;

16.14.9 Put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of an MCO’s span of control. This includes, but is not limited to, any provider or member service applications that are directly accessible over the Internet, shall be appropriately isolated to ensure appropriate access;

16.14.10 Ensure that remote access users of its Systems can only access said Systems through two-factor user authentication and via methods such as Virtual Private Network (VPN), which must be prior approved by DHH no later than fifteen (15) calendar days after the Contract award; and

16.14.11 Comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. As a minimum, the MCO shall conduct a security risk assessment and communicate the results in an information security plan provided no later than fifteen (15) calendar days after the Contract award. The risk assessment shall also be made available to appropriate federal agencies.

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17.0 CLAIMS MANAGEMENT

17.1 Functionality

17.1.1 The MCO shall maintain an electronic claims management system that will:

17.1.1.1 Uniquely identify the attending and billing provider of each service;

17.1.1.2 Identify the date of receipt of the claim (the date the MCO receives the claim as indicated by the date stamp on the claim);

17.1.1.3 Identify real-time accurate history with dates of adjudication results of each claim such as paid, denied, pended, adjusted, voided, appealed, etc., and follow up information on disputed claims;

17.1.1.4 Identify the date of payment, (the date of the check or other form of payment), and the number of the check or electronic funds transfer (EFT);

17.1.1.5 Identify all data elements as required by DHH for encounter data submission as stipulated in this Section of the RFP and the ***MCO Systems Companion Guide***;

17.1.1.6 Accept submission of paper-based claims and electronic claims by contracted providers, and non-participating providers according to the MCO policies as approved by DHH;

17.1.1.7 Accept submission of electronic adjustment and void transactions;

17.1.1.8 Accept submission of paper adjustment and void transactions;

17.1.1.9 Have capability to pay claims at $0.00; and

17.1.1.10 For the purpose of this Section, identify means to capture, edit and retain.

17.1.2 The MCO shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the MCO or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees and/or charges.

17.1.3 The MCO shall assume all costs associated with claims processing, including costs for reprocessing encounters due to errors caused by the MCO, or due to systems within the MCO's span of control.

17.1.4 The MCO shall provide on-line and phone-based capabilities to providers to obtain claim processing status information.

17.1.5 The MCO shall support a CAQH/CORE compliant interface to the automated clearinghouse (ACH) that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

17.1.6 The MCO shall have procedures approved by DHH, available to providers in written and web form for the acceptance of claim submissions which include:

17.1.6.1 The process for documenting the date of actual receipt of non-electronic claims and date and time of electronic claims;

17.1.6.2 The process for reviewing claims for accuracy and acceptability;

17.1.6.3 The process for prevention of loss of such claims, and

17.1.6.4 The process for reviewing claims for determination as to whether claims are accepted as clean claims.

17.1.7 The MCO shall not employ off-system or gross adjustments when processing corrections for payment errors, unless the MCO requests and receives prior written approval from DHH.

17.1.8 For purposes of network management, the MCO shall notify all contracted providers to file claims associated with covered services directly to the MCO, or its sub-contractors, on behalf of Louisiana Medicaid members.

17.1.9 The MCO agrees that at such time that DHH presents recommendations concerning claims billing and processing that are consistent with industry norms, the MCO shall comply with said recommendations within ninety (90) calendar days from notice by DHH.

17.2 Claims Processing

17.2.1 The MCO shall ensure that all provider claims are processed according to the following timeframes:

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

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

17.2.1.3 Process and pay or deny, as appropriate, at least Ninety-nine percent (99%) of all clean claims for each claim type, within thirty (30) calendar days of the date of receipt.

17.2.1.4 Fully adjudicate (pay or deny) all pended claims within sixty (60) calendar days of the date of receipt.

17.2.2 Rejected Claims

17.2.2.1 The MCO may reject claims because of missing or incomplete information. Paper claims that are received by the MCO that are screened and rejected prior to scanning must be returned to the provider with a letter notifying them of the rejection. Paper claims received by the MCO that are scanned prior to screening and then rejected, are not required to accompany the rejection letter.

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

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

- The date the letter was generated;
- The patient or member name;
- Provider identification, if available, such as provider ID number, TIN or NPI;
- The date of each service;
- The patient account number assigned by the provider;
- The total billed charges;
- The date the claim was received; and
- The reasons for rejection.

17.2.3 Pended Claims

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

17.2.4 Adjustments and Voids

17.2.4.1 Incorrect claims payments may be adjusted or voided either electronically or hard copy. Adjustments/Voids must be submitted on the correct adjustment/void forms.

17.2.4.2 Only one internal control number (ICN) should be adjusted or voided on each form.

17.2.4.3 Only a paid claim can be adjusted or voided.

17.2.4.4 Incorrect provider numbers, incorrect ~~or~~ member Medicaid ID numbers, or incorrect claim types cannot be adjusted. The encounter record ~~claim~~ must be voided and re submitted as an original. All other adjustments to an encounter record shall be done as an adjustment record~~then resubmitted~~.

17.2.5 Timely Filing Guidelines

17.2.5.1 Medicaid-only claims must be filed within three hundred sixty five (365) days of the date of service.

17.2.5.2 ~~The MCO shall not deny provider claims on the basis of untimely filing in situations regarding coordination of services or subrogation, in which case the provider is pursuing payment from a third party.~~ Claims involving third

party liability shall be submitted within 365 days from the date of service. Medicare claims shall be submitted within six (6) months of Medicare adjudication.

~~17.2.5.2~~17.2.5.3 The MCO must deny any claim not initially submitted to the MCO by the three hundred and sixty-fifth (365) calendar day from the date of service, unless DHH, the MCO or its sub-contractors created the error. ~~If a provider files erroneously with another MCO or with DHHs FI, but produces documentation verifying that the initial filing of the claim occurred timely, within the one hundred and eighty (180) three hundred and sixty five (365) calendar day period, the MCO shall process the provider's claim and not deny for failure to meet timely filing guidelines.~~ The MCO shall not deny claims solely for failure to meet timely filing guidelines due to error by DHH or its subcontractors.

17.2.5.4 For purposes of MCO reporting on payment to providers, an adjustment to a paid claim shall not be counted as a claim and electronic claims shall be treated as identical to paper based claims.

~~17.2.5.3~~17.2.5.5 Timely filing exception with regard to retroactive eligibility. The MCO shall not deny claims submitted in cases of retroactive eligibility for timely filing if the claims is submitted within one hundred and eighty (180) days from the member's linkage to the MCO.

17.2.6 Claim System Edits

17.2.6.1 The MCO shall perform system edits, including, but not limited to:

17.2.6.1.1 Confirming eligibility on each member;

17.2.6.1.2 Validating member name;

17.2.6.1.3 Validating unique member identification number;

17.2.6.1.4 Validating date of service - Perform system edits for valid dates of service, and assure that dates of services are valid dates such as not in the future or outside of a member's Medicaid eligibility span;

17.2.6.1.5 Determination of medical necessity - by a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity;

17.2.6.1.6 Prior Approval – The system shall determine whether a covered service required prior authorization and if so, whether the MCO granted such approval;

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

17.2.6.1.8 Covered Services - Ensure that the system verifies that a service is a covered service and is eligible for payment;

17.2.6.1.9 Provider Validation - Ensure that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted and that the provider has not been excluded from receiving Medicaid payments as stipulated in Section 9.4; and

17.2.6.1.10 Quantity of Service - Ensure that the System shall evaluate claims for services provided to members to ensure that any applicable benefit limits are applied.

17.2.6.2 Perform post-payment review on a sample of claims to ensure services provided were medically necessary.

17.2.6.3 The MCO shall have the ability to update CPT/HCPCS, ICD-9-CM, and other codes based on HIPAA standards and move to future versions as required.

17.2.6.4 The MCO shall comply with use of ICD-10 code sets based on deadlines established by CMS, and comply with DHH deadlines for communication, testing, and implementation.

17.2.6.5 In addition to CPT, ICD-9-CM, ICD-10-CM, ICD-10-PCS and other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the MCO and DHH to evaluate performance measures.

17.3 Payment to Providers

17.3.1 At a minimum, the MCO shall run one (1) provider payment cycle per week, on the same day each week, as determined by the MCO.

17.3.2 The MCO shall encourage that its providers, as an alternative to the filing of paper-based claims, submit and receive claims information through electronic data interchange (EDI).

17.3.3 The MCO shall pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean claim remains unpaid beyond the thirty (30) day claims processing deadline. Interest owed to the provider must be paid the same date that the claim is adjudicated, and reported on the encounter submission to the FI as defined in the MCO Systems Companion Guide.

17.3.4 The MCO shall pay pharmacy providers no less than the DHH specified dispensing fee. In addition, any state imposed provider fees for pharmacy services, shall be added on top of the minimum dispensing fee required by DHH.

17.4 Remittance Advices

In conjunction with its payment cycles, the MCO shall provide:

17.4.1 Each remittance advice generated by the MCO to a provider shall comply with the provisions of LA-R.S. 46:460.71.

~~The~~

17.4.2 Adjustments and Voids shall appear on the RA under "Adjusted or Voided claims" either as Approved or Denied.

17.4.3 In accordance with 42 CFR §455.18 and §455.19, the following statement shall be included on each remittance advice sent to providers: "*I understand that* payment *and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws."*

17.5 Sampling of Paid Claims

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

- Description of the service furnished;
- The name of the provider furnishing the service;
- The date on which the service was furnished; and
- The amount of the payment made for the service.

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

17.5.3 Surveys may be performed at any point after a claim has been paid. This sampling may be performed by mail, telephonically or in person (e.g., case management on-site visits). Concurrent review will be allowed when tied back to a successfully adjudicated claim.

17.5.4 The MCO shall track any grievances received from members and resolve the grievances according to its established policies and procedures. The resolution may be member education, provider education, or referral to DHH. The MCO shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.

17.5.5 Within three (3) business days, results indicating that paid services may not have been received, shall be referred to the MCO's fraud and abuse department for review and to DHH through the following url: http://new.dhh.louisiana.gov/index.cfm/page/219 or DHH prior approved method.

17.5.6 Reporting shall include the total number of survey notices sent out to members, total number of surveys completed, total services requested for validation,

number of services validated, analysis of interventions related to grievance resolution, and number of surveys referred to DHH for further review.

17.6 Claims Dispute Management

17.6.1 The MCO shall develop an internal claims dispute process for those claims or group of claims that have been denied or underpaid. The process must be submitted to DHH for approval within thirty (30) days of the date the Contract is signed by the MCO.

17.6.2 The Claims Dispute process shall allow providers the option to request binding arbitration for claims that have denied or underpaid claims or a group of claims bundled, by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the MCO and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Section shall be binding on all parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) days of being selected, unless the MCO and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

17.6.3 The MCO shall systematically capture the status and resolution of all claim disputes as well as all associated documentation.

17.6.4 The MCO shall adjudicate all disputed claims to a paid or denied status within thirty (30) business days of receipt of the dispute claim.

~~**17.6.5**~~ The MCO shall resolve all disputed claims, no later than twenty-four (24) months from the date of service.

~~**17.6.6**~~**17.6.5**

17.7 Claims Payment Accuracy Report

17.7.1 On a monthly basis, the MCO shall submit a claims payment accuracy percentage report to DHH. The report shall be based on an audit conducted by the MCO. The audit shall be conducted by an entity or staff independent of claims management as specified in this Section of the RFP, and shall utilize a randomly selected sample of all processed and paid claims upon initial submission in each month. A minimum sample consisting of two hundred (200) to two hundred-fifty (250) claims per year, based on financial stratification, shall be selected from the entire population of electronic and paper claims processed or paid upon initial submission.

17.7.2 The minimum attributes to be tested for each claim selected shall include:

- Claim data is correctly entered into the claims processing system;
- Claim is associated with the correct provider;
- Proper authorization was obtained for the service;

- Member eligibility at processing date correctly applied;
- Allowed payment amount agrees with contracted rate;
- Duplicate payment of the same claim has not occurred;
- Denial reason is applied appropriately;
- Co-payments are considered and applied, if applicable;
- Effect of modifier codes correctly applied; and
- Proper coding.

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

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

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

17.8 Encounter Data

17.8.1 The MCO's System shall be able to transmit to and receive encounter data from the DHH FI's system as required for the appropriate submission of encounter data.

17.8.2 Each MCO shall create a unique Processor Control Number (PCN) or Group number for Louisiana Medicaid. The health plan shall submit the PCN or group number and the Bank Identification Number with the encounter claims data submission.

17.8.3 For encounter data submissions, the MCO shall:

17.8.3.1 Submit complete and accurate encounter data at least monthly;

17.8.3.2 Due no later than the twenty-fifth (25th) calendar day of the month following the month in which they were processed (paid or denied), including encounters reflecting a zero dollar amount ($0.00) and encounters in which the MCO or its subcontractor has a capitation arrangement with a provider. If the MCO fails to submit complete encounter data, including encounters processed by subcontracted vendors (e.g., pharmacy, non-emergency transportation, vision) as measured by a comparison of encounters to cash disbursements within a five (5) percent error threshold (at least ninety-five (95) percent complete), the plan may be penalized as outlined in Section 20 of the RFP.

~~**17.8.4**~~ DHH's current FI accepts HIPAA compliant 837 encounters for Institutional, Professional and Dental. DHH"s FI accepts ~~at a document level, with the exception of~~ Pharmacy encounters using the NCPDP D.0 format in a batch processing method.~~, which are accepted at a line level.~~ The MCO shall be able to transmit encounter data to~~from~~ the FI in this manner sixty (60) days after the contract start date.. Inpatient Hospital services (Institutional~~.~~

~~**17.8.4.1**~~**17.8.3.3** ~~When the FI adjudicates~~ encounters indicating Facility Type Code of 11, 12, 18, 21 or 86)~~, the inpatient hospital encounters~~ are adjudicated at the~~a~~ document ~~-~~level.~~-~~ All other encounters are adjudicated ~~by the FI~~ at the line ~~-~~level~~.~~

~~**17.8.5**~~**17.8.4** Within sixty (60) days of operation, the MCO's System shall be ready to submit encounter data to the FI in a provider-to-payer-to-payer COB format. The MCO must incur all costs associated with certifying HIPAA transactions readiness through a third party, EDIFECS, prior to submitting encounter data to the FI. Data elements and reporting requirements are provided in the **MCO Systems Companion Guide.**

- All encounters shall be submitted electronically in the standard HIPAA 5010 transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB Transaction formats (P – Professional, I – Institutional and NCPDP Pharmacy). Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.

- The MCO shall provide DHH with weekly encounter data on all prior authorization requests. The data shall be reported electronically to DHH in a mutually agreeable format as specified in the MCO Systems Companion Guide.~~ .~~ Contractor shall report prior authorization requests on all services which require prior authorization. The information reported shall contain but not be limited to:
  - Plan ID
  - Plan Authorization Number
  - Authorization Type
  - Medicaid Recipient ID
  - Provider NPI
  - Provider Taxonomy
  - CPT / NDC/HICL/THERP CLASS
  - CPT Modifiers 1

- CPT Modifiers 2
- CPT Modifiers 3
- CPT Modifiers 4
- Referring Provider NPI
- Plan Authorization Status
- Authorization begin date
- Authorization end date
- Authorization Units
- Authorization amount ($)
- Authorization received date
- Authorization notice date
- Authorization Denied Reason

~~17.8.6~~17.8.5 The MCO shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided, including all claims paid, denied or adjusted directly by the MCO or indirectly through a subcontractor.

~~17.8.7~~17.8.6 The MCO shall have the capability to convert, all information that enters its claims system via hard copy paper claims, to electronic encounter data, for submission in the appropriate HIPAA compliant formats to DHH's FI.

~~17.8.8~~17.8.7 The MCO shall ensure that all encounter data from an MCO sub-contractor is incorporated into files submitted by the MCO to the FI. The MCO shall not submit separate encounter files from MCO sub-contractors.

~~17.8.9~~17.8.8 The MCO shall ensure the level of detail associated with encounters from providers with whom the MCO has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the MCO received and settled a fee-for-service claim.

~~17.8.10~~17.8.9 The MCO shall utilize DHH provider billing manuals and become familiar with the claims data elements that must be included in encounters. The MCO shall retain all required data elements in claims history for the purpose of creating encounters that are compatible with DHH and its FI's billing requirements.

~~17.8.11~~17.8.10 The MCO shall adhere to federal and/or DHH payment rules in the definition and treatment of certain data elements, such as units of service that are a standard field in the encounter data submissions and will be treated similarly by DHH across all MCOs.

~~17.8.12~~17.8.11 The MCO shall submit paid, denied, adjusted, and voided claims as encounters to the FI. DHH will establish the appropriate identifiers to indicate these claims as encounters, and information will be provided in the MCO Systems Companion Guide.

~~17.8.13~~17.8.12 The MCO shall ensure that encounter files contain settled claims, adjustments, denials or voids, including but not limited to adjustments necessitated by payment errors, processed during that payment cycle, as well

as encounters processed during that payment cycle from providers with whom the MCO has a capitation arrangement.

~~17.8.14~~17.8.13 The FI encounter process shall utilize a DHH-approved version of the claims processing system (edits and adjudication) to identify valid and invalid encounter records from a batch submission by the MCO. Any submission which contains fatal errors that prevent processing, or that does not satisfy defined threshold error rates, will be rejected and returned to the MCO for correction and resubmission to the FI in the next payment cycle.

~~17.8.15~~17.8.14 DHH has authorized their FI to edit MCO encounters using a common set of edit criteria, that might cause denials, and MCOs should resolve denied encounters when appropriate. Encounter denial codes shall be deemed "repairable" or "non-repairable". An example of a repairable encounter is "provider invalid for date of service". An example of a non-repairable encounter is "exact duplicate". The MCO is required to be familiar with the FI edit codes and dispositions for the purpose of repairing encounters denied by the FI. A list of encounter edit codes is located in the **MCO Systems Companion Guide.**

~~17.8.16~~17.8.15 In order to maintain integrity of processing, the MCO shall address any issues that prevent processing of an encounter. Acceptable standards shall be ninety percent (90%) of reported repairable errors are addressed within thirty (30) calendar days and ninety-nine percent (99%) of reported repairable errors within sixty (60) calendar days or within a negotiated timeframe approved by DHH. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan, may result in monetary penalties.

~~17.8.17~~17.8.16 The MCO CEO, CFO or their designee shall attest to the truthfulness, accuracy, and completeness of all encounter data submitted.

~~17.8.18~~17.8.17 MCO must make an adjustment to encounter claims when MCO discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed except as noted otherwise. If DHH or its subcontractors discover errors or a conflict with a previously adjudicated encounter claim MCO shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by DHH or if circumstances exist that prevent contractor from meeting this time frame a specified date shall be approved by DHH. MCO must obtain prior approval from DHH for any submission to DHH's Fiscal Intermediary that numbers greater than one hundred thousand (100,000) encounter claims.

17.9 Claims Summary Report

17.9.1 The MCO must submit monthly, Claims Summary Reports of paid and denied claims, to DHH by claim type. Instructions are provided in the **MCO Systems Companion Guide**.

17.10 Pharmacy Claims Processing

17.10.1 System Requirements

17.10.1.1 The MCO shall have an automated claims and encounter processing system for pharmacy claims that will support the requirements of this contract and ensure the accurate and timely processing of claims and encounters.

17.10.1.2 Transaction standards: The MCO shall support electronic submission of claims using most current HIPAA compliant transaction standard (currently NCPDP D.0)

17.10.1.3 Pharmacy claim edits shall include eligibility, drug coverage, benefit limitations, prescriber and prospective/concurrent drug utilization review edits.

17.10.1.4 The system shall provide for an automated update to the National Drug Code file including all product, packaging, prescription and pricing information. The system shall provide online access to reference file information. The system should maintain a history of the pricing schedules and other significant reference data. The drug file for both retail and specialty drugs, including price, must be updated at a minimum every seven (7) calendar days, at the MCO's discretion they may update the file more frequently.

17.10.1.5 The MCO must comply with the claims history requirements in Section 16.13. The historical encounter data submission shall be retained for a period not less than six (6) years, following generally accepted retention guidelines.

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

17.10.1.7 The MCO shall ensure that the manufacturer number, product number, and package number for the drug dispensed shall be listed on all claims. This information shall be taken from the actual package from which the drug is usually purchased by a provider, from a supplier whose products are generally available to all pharmacies and reported in one or more national compendia.

17.10.1.8 Provisions should be made to maintain permanent history by service date for those services identified as "once-in-a-lifetime."

17.10.2 Pharmacy Rebates

The MCO shall submit all drug encounters, with the exception of inpatient hospital drug encounters, to DHH pursuant to the requirements of Section 17.10.3 of this contract. DHH or its vendor shall submit these encounters for federal supplemental pharmacy rebates from manufacturers under the authority of the DHH Secretary pursuant to the Section 2501 of the Patient Protection and Affordable Care Act (PPACA).

17.10.3 Pharmacy Encounters Claims Submission

17.10.3.1 The MCO shall submit a weekly claim-level detail file of pharmacy encounters to DHH which includes individual claim-level detail information on each

pharmacy claim dispensed to a Medicaid patient, including but not limited to the total number of metric units, dosage form, strength and package size, National Drug Code of each covered outpatient drug dispensed to Medicaid enrollees. This weekly submission must comply with Section 17.88 requirements. See the MCO Systems Companion Guide for a complete listing of claim fields required.

17.10.3.2 The MCO must ensure that its pharmacy claims process recognizes claims from 340B pharmacies for products purchased through the 340B discount drug program at the claim level utilizing the NCPDP field designed for this purpose.

17.10.4 Disputed Pharmacy Encounter Submissions

17.10.4.1 On a weekly basis, DHH will review the MCO's pharmacy encounter claims and send a file back to the MCO of disputed encounters that were identified through the drug rebate invoicing process.

17.10.4.2 Within 60 calendar days of receipt of the disputed encounter file from DHH, the MCO shall, if needed, correct and resubmit any disputed encounters and send a response file that includes 1) corrected and resubmitted encounters as described in the Rebate Section of the **MCO Systems Companion Guide**, and/or 2) a detailed explanation of why the disputed encounters could not be corrected including documentation of all attempts to correct the disputed encounters at an encounter claim level detail, as described in the Rebate Section of the **MCO Systems Companion Guide**.

17.10.4.3 In addition to the administrative sanctions in Section 20 of this contract, failure of the MCO to submit weekly pharmacy encounter claims files and/or a response file to the disputed encounters file within sixty (60) calendar days as detailed above for each disputed encounter will result in a quarterly offset to the capitation payment equal to the value of the rebate assessed on the disputed encounters being deducted from the MCO's capitation payment.

17.10.5 Use of a Pharmacy Benefits Manager (PBM)

17.10.5.1 The MCO must use a PBM to process prescription claims. The PBM must pay claims in accordance with Section 17 of this contract.

17.10.5.2 The MCO must identify the proposed PBM and the ownership of the proposed PBM. Before entering into a subcontract with a PBM, the MCO shall obtain DHH approval. If the PBM is owned wholly or in part by a retail pharmacy provider, chain drug store or pharmaceutical manufacturer, the MCO will submit a written description of the assurances and procedures that must be put in place under the proposed PBM subcontract, such as an independent audit, to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information. The MCO must provide a plan documenting how it will monitor such Subcontractors. These assurances and procedures must be transmitted to DHH for review and approval prior to the date pharmacy services begin.

17.10.5.3 The MCO must submit a plan for oversight of the PBM's performance prior to the implementation of the MCO's PBM. The plan must be approved by DHH and comply with this contract and all DHH requirements.

17.11 Audit Requirements

The MCO shall ensure that their Systems facilitate the auditing of individual claims. Adequate audit trails shall be provided throughout the Systems. To facilitate claims auditing, the MCO shall ensure that the Systems follows, at a minimum, the guidelines and objectives of the American Institute of Certified Public Accountants (AICPA) *Statement on Standards for Attestation Engagements (SSAE) No. 16*, *Reporting on Controls at a Service Organization*.

17.11.1 State Audits

17.11.1.1 The MCO shall provide to state auditors (including legislative auditors), or their designee, upon written request, files for any specified accounting period that a valid Contract exists in a file format or audit defined media, magnetic tapes, CD or other media compatible with DHH and/or state auditor's facilities. The MCO shall provide information necessary to assist the state auditor in processing or utilizing the files.

17.11.1.2 If the auditor's findings point to discrepancies or errors, the MCO shall provide a written corrective action plan to DHH within ten (10) business days of receipt of the audit report.

17.11.2 Independent Audits

17.11.2.1 The MCO shall, at its own expense, be required to submit to an annual independent Statement on Standards for Attestation Engagements (SSAE) No. 16 Service Organization Control (SOC) Type II audit of its internal controls and other financial and performance systems by an external company to ensure financial and operational viability and to ensure contract compliance. The audit period must be 12 consecutive months with no breaks between subsequent audit periods.

17.11.2.2 The Contractor shall supply the Department with an exact copy of the report by March 31st of each year.

17.11.2.3 DHH shall use the findings and recommendations of each report as part of its monitoring process.

17.11.2.4 The MCO shall deliver to DHH a corrective action plan to address deficiencies identified during the audit within ten (10) business days of receipt of the audit report.

17.11.2.5 These audit requirements are also applicable to any subcontractors or vendors delegated the responsibility of adjudicating claims on behalf of the Contractor. The cost of the audit shall be borne by the MCO or subcontractor.

17.11.3 Audit Coordination and Claims Reviews

17.11.3.1 The MCO shall coordinate audits with the Department or designee and respond within thirty (30) calendar days of a request by the Department regarding the MCO's review of a specific provider and/or claim(s), and the issue reviewed.

17.11.3.2 In the event the Department or its designee identifies a mispayment, the MCO shall have thirty (30) calendar days from the date of notification of mispayments to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department or designee. The MCO shall not correct the claims upon notification by the Department or designee, unless directed to do so by the Department.

17.11.3.3 DHH reserves the right to review any claim paid by the MCO or designee. The MCO has the right to collect or recoup any overpayments identified by the MCO from providers of service in accordance with existing laws or regulations. If an overpayment is identified by the State or its designee after a one year period from ~~payment~~date of service of the claim, the MCO will collect and remit the overpayment to DHH. In the event the MCO does not collect mispayments from the provider within thirty (30) calendar days of notification of the overpayment, the MCO shall refund the overpayment to the Department. Failure by the MCO to collect from the provider does not relieve the MCO from remitting the identified overpayment to DHH.

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18.0 REPORTING

The MCO shall comply with all the reporting requirements established by this Contract and in accordance with any DHH issued companion and reporting guide(s). As per 42 CFR §438.242(a)(b)(1)-(3), the MCO shall maintain a health information system that collects, analyzes, integrates and reports data that complies with DHH and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and member disenrollment for reasons other than loss of Medicaid eligibility. The MCO shall collect data on member and provider characteristics and on services furnished to members.

The MCO shall create deliverables which may include documents, manuals, files, plans, and reports using the electronic formats, instructions, and timeframes as specified by DHH and at no cost to DHH. Any changes to the formats must be approved by DHH prior to implementation.

The MCO shall provide DHH with a sample of all reports within forty-five (45) calendar days following the date the Contract is signed.

In the event that there are no instances to report, the MCO shall submit a report so stating.

As required by 42 CFR §438.604(a) and (b), and 42 CFR §438.606, the MCO shall certify all submitted data, documents and reports. The data that must be certified include, but are not limited to, enrollment information, financial reports, encounter data, and other information as specified within the Contract and this RFP. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The MCO must submit the certification concurrently with the certified data and documents. DHH will identify specific data that requires certification.

The data shall be certified by one of the following:

- MCO's Chief Executive Officer (CEO);
- MCO's Chief Financial Officer (CFO); or
- An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

The MCO shall provide the necessary data extracts to the DHH Data Warehouse as required by this contract.

18.1 Ownership Disclosure

Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR §455.100-455.106.) The **Medicaid Ownership and Disclosure Form** (Appendix VV) is to be submitted to DHH with the proposal; then resubmitted prior to implementation for each Contract period, annually, and within thirty-five (35) days when any change in the MCO's management, ownership or control occurs.

18.2 Information Related to Business Transactions

18.2.1 The MCO shall furnish to DHH and/or to the HHS, information related to significant business transactions as set forth in 42 CFR §455.105. Failure to comply with this requirement may result in termination of this Contract.

18.2.2 The MCO shall submit, within thirty-five (35) days of a request made by DHH, full and complete information about:

18.2.2.1 The ownership of any subcontractor with whom the MCO has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of this request; and

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

18.2.4 For the purpose of this Contract, "significant business transactions" means any business transaction or series of transactions during any state fiscal year that exceed the $25,000 or five (5%) percent of the MCO's total operating expenses whichever is greater.

18.3 Report of Transactions with Parties in Interest

18.3.1 The MCO shall report to DHH all "transactions" with a "party in interest" (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act.

18.3.2 Federally qualified MCOs are exempt from this requirement. DHH may require that the information on business transactions be accompanied by a consolidated financial statement for the MCO and the party in interest.

18.3.3 If the MCO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed.

18.3.4 The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the MCO's business transactions must be reported.

18.3.5 If the contract is renewed or extended, the MCO must disclose information on business transactions which occurred during the prior contract period.

18.4 Key Staff Reporting

18.4.1 The MCO must submit to the DHH the following staff-related items annually:

18.4.1.1 An updated organization chart complete with the Key Staff positions. The chart must include the person's name, title and telephone number and portion of time allocated to the Louisiana Medicaid contract, other Medicaid contracts, and other lines of business.

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

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

18.5 Encounter Data

18.5.1 The MCO shall comply with the required format provided by DHH. Encounter data includes claims paid or denied by the MCO or the MCO's subcontractors for services delivered to enrollees through the MCO during a specified reporting period. DHH collects and uses this data for many reasons such as: federal reporting, rate setting, risk adjustment, service verification, managed care quality improvement program, utilization patterns and access to care, DHH hospital rate setting and research studies.

18.5.2 DHH may change the Encounter Data Transaction requirements, current specifications are included in the ***MCO Systems Companion Guide***, with ninety (90) calendar days written notice to the MCO. The MCO shall, upon notice from DHH, provide notice of changes to subcontractors.

18.6 Financial Reporting

18.6.1 The MCO shall submit to DHH unaudited quarterly financial statements and an annual audited financial statement, using the required format provided by DHH. Quarterly financial statements shall be submitted no later than sixty (60) days after the close of each calendar quarter. Audited annual statements shall be submitted no later than six (6) months after the close of the MCO's fiscal year.

18.6.2 The financial statements shall be specific to the operations of the MCO rather than to a parent or umbrella organization. Audited annual statements of a parent organization, if available, shall be also submitted.

18.6.3 All financial reporting shall be based on Generally Accepted Accounting Principles (GAAP).

18.6.4 In order to evaluate and monitor the performance and operations of the MCO relative to the provision of specialized behavioral health services, to report to CMS as required for the behavioral health services federal authorities, and to assist in any future actuarial rate development, the MCO shall provide financial and utilization data in a format prescribed and provided by DHH to include, but not be limited to, detailed administrative and service costs broken out by defined group and service and utilization reporting inclusive of average lengths of stay and costs per person.

18.7 Information on Persons Convicted of Crimes

The MCO shall furnish DHH information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR §455.106. Failure to comply with this requirement may lead to termination of this Contract.

18.8 Errors

18.8.1 The MCO agrees to prepare complete and accurate reports for submission to DHH. If after preparation and submission, an MCO error is discovered either by the MCO or DHH; the MCO shall correct the error(s) and submit accurate reports as follows:

18.8.1.1 For encounters – In accordance with the timeframes specified in the Contract Monitoring and Sanctions Sections of this RFP.

18.8.1.2 For all reports – Fifteen (15) calendar days from the date of discovery by the MCO or date of written notification by DHH (whichever is earlier). DHH may at its discretion extend the due date if an acceptable plan of correction has been submitted and the MCO can demonstrate to DHH's satisfaction the problem cannot be corrected within fifteen (15) calendar days.

18.8.2 Failure of the MCO to respond within the above specified timeframes may result in a loss of any money due the MCO and the assessment of liquidated damages as provided in Contract Monitoring and Sanctions Sections of this RFP.

18.9 Submission Timeframes

18.9.1 The MCO shall ensure that all required deliverables, which may include documents, manuals, files, plans, and reports, as stated in this RFP, are submitted to DHH in a timely manner for review and approval. The MCO's failure to submit the deliverables as specified may result in the assessment of liquidated damages, as stated in the Contract Monitoring and Sanctions Sections of this RFP.

18.9.2 DHH may, at its discretion, require the MCO to submit additional deliverables both *ad hoc* and recurring. If DHH requests any revisions to the deliverables already submitted, the MCO shall make the changes and re-submit the deliverables, according to the time period and format required by DHH. A sixty (60) day notice will be given on changes to all on-going reports.

18.9.3 Unless otherwise specified in the contract, deadlines for submitting deliverables are as follows:

18.9.3.1 Monthly deliverables shall be submitted no later than the fifteenth (15) calendar day of the following month;

18.9.3.2 Quarterly deliverables shall be submitted by April 30, July 30, October 30, and January 30, for the calendar quarter immediately preceding the due date;

18.9.3.3 Annual reports and files, and other deliverables due annually, shall be submitted within thirty (30) calendar days following the twelfth (12th) month of the contract year; except those annual reports that are specifically exempted from this 30-calendar-day deadline by this Contract. This Contract will specify the due date of any annual report it exempts from this 30-calendar-day deadline; and

18.9.3.4 If a due date falls on a weekend or State-recognized holiday, deliverables will be due the next business day.

18.9.4 Extension deadline request for deliverables may be honored on a rare, non-routine basis only with advance notice. No request will be approved after the due date. The required advance notice period is a minimum three (3) business days, however situational circumstance extension deadline requests will be considered until COB on the due date. All deadline extension requests must be submitting in writing via electronic mail and include the reason for the request, the anticipated delivery date, and be submitted to DHH before COB on the due date.

18.10 Recurring Reports

18.10.1 The MCO shall prepare and submit deliverables in the report format prescribed by DHH.

18.10.2 A list of recurring deliverable reports is summarized and posted to the DHH webpage for Medicaid MCOs: http://new.dhh.louisiana.gov/index.cfm/page/1700

18.10.3 The DHH webpage indicated above will serve as the definitive source of all required recurring deliverable reports and will be updated by DHH when changes are made as stipulated.

18.11 *Ad Hoc* Reports

18.11.1 The MCO shall prepare and submit any other reports as required and requested by DHH, any of DHH's designees, Legislature and/or CMS, that is related to the MCO's duties and obligations under this Contract. Information considered to be of a proprietary nature shall be clearly identified as such by the MCO at the time of submission.

18.11.2 *Ad Hoc* reports shall be submitted within five (5) business days from the date of request, unless otherwise approved by DHH.

18.12 Pharmacy Reporting

18.12.1 The MCO shall provide additional reporting specific to the pharmacy program, including, but not limited to:

- Pharmacy help desk performance
- Prior authorization performance
- Prior Authorization request turnaround time
- Number of claims submitted as a 72-hour emergency supply
- Denials (name of drug, number of requests, number of denials)
- Pharmacy network access
- Grievance and appeals
- Medication therapy management initiatives

18.13 PASRR Reporting

18.13.1 The MCO shall report to DHH indicators relative to individual evaluations on a monthly basis with information available by region, type of placements, results of recommendations, location of individuals and referral sources as outlined in the Behavioral Health Companion Guide.

~~18.13~~18.14 Court-Ordered Reporting

The MCO shall comply with all court-ordered reporting requirements currently including but not limited to the *Wells v. Kliebert* and *Chisholm v. Kliebert* cases in the manner determined by DHH.

18.15 Substance Abuse and Mental Health Block Grant Data Collection Requirements

18.15.1 The MCO may be required to provide DHH-OBH reliable and valid data to meet federal reporting requirements for the SAMHSA-funded SABG and MHBG Block Grants for populations and services covered in this contract as detailed in the Behavioral Health Companion Guide.

~~18.14~~18.16 Report Submission

~~18.14.1~~18.16.1 For quality measures and administrative measures, MCOs shall use the Quality Reporting Document Architecture – Category III document format that provides a standard structure with which to report aggregated quality measure data.

~~18.14.2~~18.16.2 Reports will be submitted in electronic format as structured data only using Health Level 7 messaging at such time as DHH requests.

~~Court-Ordered Reporting~~

~~The MCO shall comply with all court-ordered reporting requirements currently including but not limited to the Wells v. Kliebert and Chisholm v. Kliebert cases in the manner determined by DHH.~~

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19.0 CONTRACT MONITORING

BHSF will be responsible for the primary oversight of the Contract, including Medicaid policy decision-making and Contract interpretation. As appropriate, BHSF will provide clarification of MCO requirements and Medicaid policy, regulations and procedures and will schedule meetings as necessary with the MCO.

19.1. Contract Personnel

19.1.1. Liaisons

The MCO shall designate an employee of its administrative staff to act as the primary liaison between the MCO and DHH for the duration of the Contract. DHH's Medicaid Managed Care Section will be MCO's principal point of contact and shall receive all inquiries and requests for interpretation regarding the Contract and all required reports unless otherwise specified in the Contract. The MCO shall also designate a member of its senior management who shall act as a liaison between the MCO's senior management and DHH when such communication is required. If different representatives are designated after approval of the Contract, notice of the new representative shall be provided in writing within seven (7) calendar days of the designation.

19.1.2. Contract Monitor

All work performed by the MCO will be monitored by the Medicaid Director or his/her designee:

Medicaid Health Plan Relations ~~Director~~
Department of Health and Hospitals
Bureau of Health Services Financing
628 North 4th St., 7th floor
Baton Rouge, LA 70821

19.2. Notices

Any notice given to a party under the Contract is deemed effective, if addressed to the party as addressed below, upon: (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by facsimile or email if a copy of the notice is sent by another means specified in this Section; (iii) the third Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

DHH Bureau of Health Services Financing
~~Bayou Health~~Medicaid Health Plan Relations Director
628 North 4th St., 7th floor
Baton Rouge, LA 70821
~~Email:~~
~~Contractor~~
~~Name TBD~~

Either party may change its address for notification purposes by providing written notice stating the change, effective date of change and setting forth the new address at least 10 days prior to the effective date of the change of address. If different representatives are designated after execution of the Contract, notice of the new representative will be given in writing to the other party and attached to originals of the Contract.

Whenever DHH is required by the terms of this RFP to provide written notice to the MCO, such notice will be signed by the Medicaid Director or his/her designee

19.3. Notification of MCO Policies and Procedures

DHH will provide the MCO with updates to appendices, information and interpretation of all pertinent federal and state Medicaid regulations, MCO policies, procedures and guidelines affecting the provision of services under this Contract. The MCO will submit written requests to DHH for additional clarification, interpretation or other information. Provision of such information does not relieve the MCO of its obligation to keep informed of applicable federal and state laws related to its obligations under this Contract.

19.4. Required Submissions

Within thirty (30) calendar days from the date the Contract is signed by the MCO, the MCO shall submit documents as specified in this RFP. DHH shall have the right to approve, disapprove or require modification of these documents and any procedures, policies and materials related to the MCO's responsibilities under the terms of the Contract. Refer to Appendix JJ, **Transition Requirements** for a listing of submission requirements.

19.5. Readiness Review Prior to Operations Start Date

DHH will assess the performance of the selected MCOs prior to and after the begin date for operations. DHH will complete readiness reviews of MCOs prior to implementation. This includes evaluation of all MCOs' program components including IT, administrative services and medical management. Each readiness review for entities that did not contract with DHH as a prepaid entity will be performed on site at the MCO's Louisiana administrative offices. Refer to Appendix JJ, **Transition Period Requirements**. Readiness reviews for entities that were previously contracted with DHH to serve as prepaid entities will be conducted via desk audit.

19.5.1. Specialized Behavioral Health Implementation

DHH shall conduct a readiness review with each MCO prior to specialized behavioral health integration. The purpose of the readiness review is to demonstrate each plan's ability to provide covered specialized behavioral health benefits and services to all assigned members. The review may consist of a desk review of policies and implementation plans, as well as, an onsite review for follow up and demonstration. Work plans, policies and capacities to be addressed may include but are not limited to:

- tasks, activities and timelines for transition
- member outreach and communication;

- member services and provisions for continuing all management and administrative services;
- plan to review authorizations;
- provider transition which shall include provider outreach;
- a dedicated plan for transitioning high risk/high need populations;
- MCO staffing and training plan;
- reporting readiness including CMS required reports;
- acceptance into its system any and all necessary data files and information available from DHH;
- assurances that member services are not interrupted or delayed during the transition;
- demonstrate its system capabilities and adherence to contract specifications during readiness review;
- systems edit review;
- proof of required staffing plan;
- hiring plan if not fully staffed and organizational charts for approval;
- proof of network adequacy;
- operations readiness;
- appropriate HIPAA and 42 CFR requirements are in place; and
- provider readiness review by MCOs

19.6. Ongoing Contract Monitoring

DHH will monitor the MCO's performance to assure the MCO is in compliance with the Contract provisions. However this does not relieve the MCO of its responsibility to continuously monitor its providers' performance in compliance with the Contract provisions.

19.6.1. DHH or its designee shall coordinate with the MCO to establish the scope of review, the review site, if on site, relevant time frames for obtaining information, and the criteria for review.

19.6.2. DHH or its designee will monitor the operation of the MCO for compliance with the provisions of this Contract, and applicable federal and state laws and regulations. Inspection may include the MCO's facilities, as well as auditing and/or review of all records developed under this Contract including, but not limited to, periodic medical audits, grievances, enrollments, disenrollment, utilization and financial records, review of the management systems and procedures developed under this Contract and any other areas or materials relevant or pertaining to this Contract.

19.6.3. The MCO shall provide access to documentation, medical records, premises, and staff as deemed necessary by DHH.

19.6.4. The MCO shall have the right to review and comment on any of the findings and recommendations resulting from Contract monitoring and audits, except in the cases of fraud investigations or criminal action. However, once DHH finalizes the results of monitoring and/or audit report, the MCO must comply with all recommendations resulting from the review. Failure to comply with recommendations for improvement may result in monetary penalties, sanctions and/or enrollment restrictions.

19.7. MCO On-Site Reviews

DHH will conduct on-site readiness reviews for entities that did not contract with DHH previously as prepaid entities prior to member enrollment under this contract and as an ongoing activity during the Contract period. The MCO's on-site review will include a desk audit and on-site focus component. The site review will focus on specific areas of MCO performance. These focus areas may include, but are not limited to the following:

- Administrative capabilities
- Governing body
- Subcontracts
- Provider network capacity and services
- Provider Complaints
- Member services
- PCP assignments and changes
- Enrollee grievances and appeals
- Health education and promotion
- Quality improvement
- Utilization review
- Data reporting
- Coordination of care
- Claims processing
- Encounter data
- Fraud and abuse

DHH will assess and communicate feedback on overall plan performance through routine meetings with MCO leadership, including but not limited to:

- Weekly in person or telephonic meetings between the Medicaid Director, Medicaid Deputy Director responsible for Bayou Health, and MCO Administrator/CEO.
- Quarterly Business Reviews wherein MCO leadership present to DHH leadership on overall MCO performance relative to DHH goals and requirements of the Contract. The reviews will take place in person at DHH headquarters on a schedule determined by DHH. DHH will notify the MCO of the schedule and any

format or content requirements at (30) days prior to the Review date. Unless otherwise specified by DHH, in person attendance by key staff as follows is mandatory:

- Administrator/Chief Executive Officer (CEO);
- Medical Director/Chief Medical Officer;
- Behavioral Health Medical Director;
- Chief Operating Officer (COO);
- Chief Financial Officer/CFO;
- Quality Management Coordinator;
- Provider Services Manager;
- Case Management Administrator/Manager; and
- Other staff as designated by DHH based on content.

Monthly combined meetings of all contracted MCOs with the Medicaid Deputy Director responsible for Bayou Health and key DHH program staff will be held in person at DHH headquarters to discuss program updates and issues, options for resolution, and action steps for implementation. Depending on the agenda, MCO staff required to attend, may vary at the discretion of DHH. Unless otherwise excused by the Deputy Director, the attendance by the following key staff is mandatory:

- Administrator/Chief Executive Officer (CEO);
- Chief Financial Officer/CFO;
- Chief Operating Officer (COO); and
- Other staff as designated by DHH based on content.

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20.0 CONTRACT NON-COMPLIANCE

When DHH identifies that the MCO is not compliant with the terms of the contract, DHH may pursue administrative actions, corrective action plans, and/or monetary penalties.

20.1. Administrative Actions

20.1.1. Administrative actions exclude monetary penalties, corrective action plans, intermediate sanctions and termination and include, but are not limited to:

- A warning through written notice or consultation;
- Education requirement regarding program policies and procedures; ~~;~~
- Review of MCO business processes;~~;~~
- Referral to the Louisiana Department of Insurance for investigation;
- Referral for review by appropriate professional organizations; and/or
- Referral to the Office of the Attorney General for fraud investigation.

20.2. Corrective Action Plans (CAP)

20.2.1. DHH may require the MCO to develop a Corrective Action Plan that includes the steps to be taken by the MCO to obtain compliance with the terms of the contract.

20.2.2. DHH shall approve and monitor implementation of the CAP through available reporting resources, on-site evaluations, or requested status reports.

20.2.3. The CAP must include a timeframe for anticipated compliance and a date certain for the correction of the occurrence.

20.2.4. DHH may impose monetary penalties if the terms of the CAP are not met. Monetary penalties will continue until satisfactory correction of the occurrence has been made as determined by DHH.

20.3. Monetary Penalties

The purpose of establishing and imposing monetary penalties is to provide a means for DHH to obtain the services and level of performance required for successful operation of the Contract. DHH's failure to assess monetary penalties in one or more of the particular instances described herein will in no event waive the right for DHH to assess additional monetary penalties or actual damages.

20.3.1. The decision to impose monetary penalties shall include consideration of the following factors:

- The duration of the violation;
- Whether the violation (or one that is substantially similar) has previously occurred;

- The MCO's history of compliance;
- The severity of the violation and whether it imposes an immediate threat to the health or safety of the Medicaid members; and
- The "good faith" exercised by the MCO in attempting to stay in compliance.

20.3.2. For purposes of this Section, violations involving different individual, unrelated enrollees shall not be considered as arising out of the same action.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**PENALTY**
Operations Start Date	Ten thousand dollars ($10,000.00) per calendar day for each day beyond the Operations Start Date that the MCO is not operational until the day that the MCO is operational, including all systems.
Provider Registry Accuracy	Two thousand dollars ($2,000) per calendar day for each day for that one or more non-contracted providers remain listed as contracted in the Electronic Provider Registry submitted by the MCO.
System Readiness Review Contingency Plan • Disaster Recovery Plan • Business Continuity Plan • Systems Quality Assurance Plan	MCO must submit to DHH or the Readiness Review Contractor the subject plans no later than 30 days after the announcement of recommendation of contract award. One thousand ($1,000.00) per calendar day for each day a deliverable is late, inaccurate, or incomplete.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**PENALTY**
Encounter Data	Ten thousand dollars ($10,000.00) per calendar day for each day after the due date that the monthly encounter data has not been received in the format and per specifications outlined in the RFP. Ten thousand dollars ($10,000.00) per calendar day for each day encounter data is received after the due date, for failure to correct and resubmit encounter data that was originally returned to the MCO for correction because submission data was in excess of the five (5) percent error rate threshold, until acceptance of the data by the fiscal intermediary. Ten thousand dollars ($10,000.00) per return by the fiscal intermediary of re-submission of encounter data that was returned to the MCO, as submission data was in excess of the five (5) percent error rate threshold, for correction and was rejected for the second time. Ten thousand dollars ($10,000.00) per occurrence of medical record review by DHH or its designee where the MCO or its provider(s) denotes provision of services which were not submitted in the encounter data regardless of whether or not the provider was paid for the service that was documented. Penalties specified above shall not apply for encounter data for the first three months after direct services to MCO members have begun to permit time for development and implementation of a system for exchanging data and training of staff and health care providers.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**PENALTY**
Pharmacy Claims Data At the request of DHH or its fiscal intermediary, plans shall submit pharmacy claims information in an electronic format that is suited to allow for integration with the State's pharmacy rebate program. DHH shall establish the frequency of these information requests, and the plans shall comply. The pharmacy rebate process is a quarterly process and claims information is usually required before the end of the month that follows the end of the quarter.	The MCO may be subject to a sanction of $10,000 per calendar day for each day the information is late; or incomplete, deficient and/or inaccurate until the information has been submitted and accepted by DHH as complete, accurate and containing no deficiencies.
Prompt Pay • Ninety percent (90%) of all clean claims must be paid within fifteen (15) business days of the date of receipt. • Ninety-nine percent (99%) of all clean claims must be paid within thirty (30) calendar days of the date of receipt. • The MCO shall pay providers interest at 12% per annum, calculated daily for the full period in which the clean claim remains unadjudicated beyond the 30-day claims processing deadline. Interest owed the provider must be paid the same date that the claim is paid.	Five thousand dollars ($5,000.00) for the each month that an MCO's claims performance percentages by claim type fall below the performance standard. Twenty-five thousand dollars ($25,000.00) for each additional month that the claims performance percentages by claim type, by MCO fall below the performance standards. One thousand dollars ($1,000.00) per claim if the MCO fails to timely pay interest.
Claims Summary Report	One thousand dollars ($1,000.00) per calendar day the report is late, inaccurate, or incomplete.
Incentive Based Performance Measure	Amounts withheld for MCO Incentive Based Performance Measure outcomes may be permanently retained upon validation of calculated rate by DHH's contracted external quality review organization.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**PENALTY**
Quality Assessment and Performance Improvement Reports	Two thousand dollars ($2,000.00) per report for each calendar day the Quality Assessment and Performance Improvement Plan (QAPI), performance measure, and/or performance improvement project reports are late or incorrect as outlined in this RFP and the *MCO Quality Companion Guide* .
Member Services Activities	Five thousand dollars ($5,000.00) per calendar day for failure to provide member services functions from 7 a.m. to 7 p.m. Central Time, Monday through Friday, to address non-emergency issues encountered by members, and 24 hours a day, 7 days a week to address emergency issues encountered by members.
Member Call Center • Operate a member call center 24/7 • Answer 95% of calls within 30 seconds • Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of calls of not more than 5% • No more than 1% of incoming calls receive a busy signal	Five thousand dollars ($5,000.00) per calendar day for failure to operate a toll-free hotline that members can call 24 hours a day, seven (7) days a week. One hundred dollars ($100.00) for each percentage point for each standard that fails to meet the requirements for a monthly reporting period per MCO. One hundred dollars ($100.00) for each 30 second time increment, or portion thereof, by which the MCOs average hold time exceeds the maximum acceptable hold time per MCO.
Provider Demographics	Fifteen thousand dollars ($15,000.00) per calendar day for failure to provide and validate provider demographic data on a semi-annual basis to ensure current, accurate, and clean data is on file for all contracted providers.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**PENALTY**
Provider Service Activities	Fifteen thousand dollars ($15,000.00) per calendar day for failure to provide for arrangements to handle emergent provider issues on a twenty-four (24) hour, seven (7) days-a-week basis. Fifteen thousand dollars ($15,000.00) per calendar day for failure to furnish provider services functions from 7 a.m. to 7 p.m. Central Time, Monday through Friday to address non-emergency issues encountered by providers.
Provider Call Center • Operate a provider call center 24/7 • Answer 95% of calls within 30 seconds • Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of calls of not more than 5% • No more than 1% of incoming calls receive a busy signal	One hundred dollars ($100.00) for each percentage point for each standard that fails to meet the requirements for a monthly reporting period per MCO. One hundred dollars ($100.00) for each thirty (30) second time increment, or portion thereof, by which the MCOs average hold time exceeds the maximum acceptable hold time per MCO.
Covered Services	Failure to provide a MCO covered service that is not otherwise associated with a performance standard and such failure results in actual harm to a member or places a member at risk of imminent harm. Fifteen thousand dollars ($15,000.00) per calendar day for each incident of non-compliance per MCO.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**PENALTY**
Management Information System	In the event of a declared major failure or disaster, the MCO's core eligibility, enrollment, and claims processing system shall be back on line within seventy-two (72) hours of the failure or disaster's occurrence. Fifteen thousand dollars ($15,000.00) per calendar day of non-compliance per MCO.
Emergency Management Plan	Ten thousand dollars ($10,000.00) per calendar day for each day the Emergency Management Plan as specified in this RFP is received after the due date or up to one hundred thousand dollars ($100,000) for failure to submit timely. However DHH may assess an additional two hundred thousand dollars ($200,000) for failure to submit the plan prior to the beginning of the Atlantic hurricane season (June 1st).
Termination Transition Plan	Failure to submit six months prior to the end of the Contract period or any extension thereof or if earlier, within thirty (30) days of Notice of Termination Ten thousand dollars ($10,000.00) per calendar day the plan is late, inaccurate, or incomplete.
Standing and *Ad Hoc* Reports	Two thousand dollars ($2,000.00) per calendar day that a report is late or incorrect.
Mental Health Rehabilitation Assessment Failure to complete greater than or equal to 90% of assessments for adult mental health rehabilitation services within fourteen (14) calendar days of referral. Failure to complete greater than or equal to 99% of assessments for adult mental health rehabilitation services within twenty-one (21) calendar days of referral.	Five Thousand dollars ($5,000) per week when MCOs performance for this indicator is below 90%. Ten Thousand dollars ($10,000) per week when MCOs performance for this indicator is below 99%.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**PENALTY**
Annual Recertification for Adult Mental Health Rehabilitation Services Failure to complete greater than or equal to 95% of annual recertifications for Adult mental health rehabilitation services within 365 days of most recent certification.	Ten thousand dollars ($10,000) per month when MCO's performance is below 95%.
Mental Health Rehabilitation Service Authorization Decision Failure to comply with mental health rehabilitation service authorization decision, as described in Section 6.37.4 Percentage of mental health rehabilitation service authorization decisions made within five (5) business days following completion of the assessment.	Ten thousand dollars ($10,000) per month when MCO's performance is below 95%.
PASRR Within 4 calendar days or receipt of referral, the MCO will submit a completed Level II evaluation to DHH-OBH.	Five thousand dollars ($5,000) per month when MCO performance for this indicator is below 95% of the total within that month.

20.3.3. DHH shall utilize the following guidelines to determine whether a report is correct and complete:

20.3.3.1. The report must contain 100% of the MCO's data; and

20.3.3.2. 99% of the required items for the report must be completed; and

20.3.3.3. 99.5% of the data for the report must be accurate as determined by edit specifications/review guidelines set forth by DHH.

20.4. Other Reporting and/or Deliverable Requirements

20.4.1. For each day that a deliverable is late, incorrect or deficient, the MCO may be liable to DHH for monetary penalties in an amount per calendar day per deliverable as specified in the table below for reports and deliverables not otherwise specified in the above Table of Monetary Penalties or expressly written elsewhere in this Contract.

20.4.2. Monetary penalties have been designed to escalate by duration and by occurrence over the term of this Contract.

Occurrence	Daily Amount for Days 1 - 14	Daily Amount for Days 15-30	Daily Amount for Days 31-60	Daily Amount for Days 61 and Beyond
1-3	$ 750	$ 1,200	$ 2,000	$ 3,000
4-6	$ 1,000	$ 1,500	$ 3,000	$ 5,000
7-9	$ 1,500	$ 2,000	$ 4,000	$ 6,000
10-12	$ 1,750	$ 3,500	$ 5,000	$ 7,500
13 and Beyond	$ 2,000	$ 4,000	$ 7,500	$10,000

20.5. Employment of Key and Licensed Personnel

20.5.1. A penalty of seven hundred dollars ($700.00) per calendar day shall be imposed for failure to have a full-time acting or permanent Administrator/CEO for more than seven (7) consecutive calendar days for each day the Administrator/CEO has not been appointed;

20.5.2. A penalty of seven hundred dollars ($ 700.00) per calendar day shall be imposed for failure to have a full-time acting or permanent Medical Director OR Behavioral Health Medical Director for more than seven (7) consecutive calendar days for each day the medical director has not been appointed.

20.5.3. A penalty of two hundred fifty dollars ($250.00) per calendar day shall be imposed for each day that personnel are not licensed as required by applicable state and federal laws and/or regulations.

20.6. Excessive Reversals on Appeal

A penalty of twenty-five thousand dollars ($25,000.00) shall be imposed for exceeding ten percent (10%) member appeals over a twelve month period (January-December or the first twelve months that the Contract is in effect) which have been overturned in a final appeal outcome for each occurrence over 10%; or for each occurrence in which the MCO does not provide the medical services or requirements set forth in a final outcome of the administrative decision by DHH or the appeals decision of the State Fair Hearing.

20.7. Marketing and Member Education Violations

20.7.1. Whenever DHH determines that the MCO or any of its agents, subcontractors, volunteers or providers has engaged in any unfair, deceptive, or prohibited marketing or member education practices in connection with proposing, offering, selling, soliciting, and providing any health care services, one or more of the remedial actions as specified in Section 20.8 shall apply.

20.7.2. Unfair, deceptive, or prohibited marketing practices shall include, but are not limited to:

- Failure to secure written approval before distributing marketing or member materials;
- Failure to secure written approval for events where marketing or member materials may be distributed;
- Engaging in, encouraging or facilitating prohibited marketing by a provider;
- Directly marketing to enrollees or potential enrollees;
- Failure to meet time requirements for communication with new members (distribution of welcome packets, welcome calls);
- Failure to provide interpretation services or make materials available in required languages;
- Engaging in any of the prohibited marketing and member education practices detailed in this RFP;
- False, misleading oral or written statement, visual description, advertisement, or other representation of any kind which has the capacity, tendency, or effect of deceiving or misleading MCO potential enrollees or enrollees with respect to any health care services, MCO or health care provider; or the DHH Bayou Health Program;
- Representation that an MCO or network provider offers any service, benefit, access to care, or choice which it does not have;
- Representation that an MCO or health care provider has any status, certification, qualification, sponsorship, affiliation, or licensure which it does not have;
- Failure to state a material fact if the failure deceives or tends to deceive;
- Offering any kickback, bribe, award, or benefit to any Medicaid eligible as an inducement to select, or to refrain from selecting any health care service, MCO, or health care provider, unless the benefit offered is medically necessary health care; and
- Use of the Medicaid eligible's or another person's information which is confidential, privileged, or which cannot be disclosed to or obtained by the user without violating a state or federal confidentiality law, including:
    - Medical records information;
    - Information which identifies the recipient or any member of his or her group as a recipient of any government sponsored or mandated health coverage program; and

- Use of any device or artifice in advertising an MCO or soliciting a Medicaid eligible which misrepresents the solicitor's profession, status, affiliation, or mission.

20.7.2.1. In order to ensure that members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, the MCO shall not have a contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another MCO or in which the MCO represents or agrees that it will not contract with another provider. The MCO shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.

20.7.2.2. If DHH determines the MCO or its subcontractors has steered potential members to join the MCO, DHH may impose the following sanctions:

- The member(s) shall be disenrolled from the MCO at the earliest effective date allowed;
- PMPMs for the months(s) the member(s) was enrolled in the MCO will be recouped;
- The MCO shall be assessed an additional $5,000 monetary sanction per member; and
- The MCO shall submit a letter to each member notifying the member of the imposed sanction and of their right to choose another MCO.

20.7.2.3. If DHH determines the MCO has violated any of the marketing and/or outreach activities outlined in the Contract, the MCO may be subject to remedial sanctions specified in Section 20.8 and/or a monetary sanction of up to $10,000 per violation/incident. The amount and type of sanctions shall be at the sole discretion of DHH.

20.8. Remedial Action(s) for Marketing Violations

20.8.1. DHH shall notify the MCO in writing of the determination of the non-compliance, of the remedial action(s) that must be taken, and of any other conditions related such as the length of time the remedial actions shall continue and of the corrective actions that the MCO must perform;

20.8.2. DHH may require the MCO to recall the previously authorized marketing material(s);

20.8.3. DHH may suspend enrollment of new members to the MCO for an amount of time specified by DHH;

20.8.4. DHH may deduct the amount of capitation payment for members enrolled as a result of non-compliant marketing practices from the next monthly capitation payment made to the MCO and shall continue to deduct such payment until correction of the failure;

20.8.5. DHH may require the MCO to contact each member who enrolled during the period while the MCO was out of compliance, in order to explain the nature of

the non-compliance and inform the member of his or her right to transfer to another MCO; or

20.8.6. DHH may prohibit future marketing activities by the MCO for an amount of time specified by DHH.

20.9. Cost Avoidance Requirements

Whenever DHH determines that the MCO is not actively engaged in cost avoidance the MCO shall be subject to sanctions in an amount not less than three (3) times the amount that could have been cost avoided.

20.10. Failure to Provide Core Benefits and Services

In the event that DHH determines that the MCO failed to provide one or more core benefits and services, DHH shall direct the MCO to provide such service. If the MCO continues to refuse to provide the core benefit or service(s), DHH shall authorize the members to obtain the covered service from another source and shall notify the MCO in writing that the MCO shall be charged the actual amount of the cost of such service. In such event, the charges to the MCO shall be obtained by DHH in the form of deductions of that amount from the next monthly capitation payment made to the MCO or a future payment as determined by DHH. With such deductions, DHH shall provide a list of the members from whom payments were deducted, the nature of the service(s) denied, and payments DHH made or will make to provide the medically necessary covered services.

20.11. Failure to Maintain an Adequate Network of Contract Providers

In the event that DHH determines that the MCO: (1) failed to maintain an adequate network of mandatory contract provider types as specified in Section 7 of this RFP, (2) failed to comply with the requirement to make three documented attempts to contract with the provider, or (3) failed to pay for medically necessary services to a non-network provider as required, a monetary penalty of up to $10,000 per incident may be assessed.

20.12. Failure to Have Subject Appropriate Staff Member(s) Attend Onsite Meeting

In the event that DHH determines that the MCO failed to provide subject appropriate staff member(s) to attend an onsite meeting, and their onsite absence jeopardizes the smooth and efficient operation of the Bayou Health Program, a monetary penalty of up to $1,000 per appropriate staff person per meeting may be assessed.

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21.0 INTERMEDIATE SANCTIONS

21.1 Acts or Failures to Act Subject to Intermediate Sanctions

Pursuant to 42 CFR §438.700, et seq., DHH may impose on the MCO intermediate sanctions if it determines that an MCO acts or fails to act as follows:

- Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under the Contract, to a member covered under the Contract;
- Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Louisiana Medicaid MCO Program;
- Acts to discriminate among members on the basis of their health status or need for health care services; this includes termination of enrollment or refusal to reenroll a member, except as permitted in Section 11.12.2 or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future medical services.
- Misrepresents or falsifies information that it furnishes to CMS or to DHH;
- Misrepresents or falsifies information that it furnishes to a member, potential member, or a health care provider;
- Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR §422.208 and §422.210;
- Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by DHH or that contain false or materially misleading information; or
- Violates any of the other applicable requirements of Section 1903(m), 1905(t)(3) or 1932 of the Social Security Act and any implementing regulations.

21.2. Other Misconduct Subject to Intermediate Sanctions

DHH also may impose sanctions against any MCO if it finds any of the following non-exclusive actions/occurrences:

- The MCO has failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from DHH;
- The MCO has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to Public Law 95-142;
- The MCO or any of its owners, officers or directors has been convicted of a criminal offense relating to performance of the Contract with DHH or of fraudulent billing practices or of negligent practice resulting in death or injury to the MCO's member;

- The MCO has presented, or has caused to be presented, any false or fraudulent claim for services or has submitted or has caused to be submitted false information to be furnished to the state or the Secretary of the federal Department of Health and Human Services;

- The MCO has engaged in a practice of charging and accepting payment (in whole or part) from members for services for which a PMPM payment was made by DHH;

- The MCO has rebated or accepted a fee or portion of fee or charge for a patient referral;

- The MCO has failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments;

- The MCO has failed to keep or make available for inspection, audit or copying, such records regarding payments claimed for providing services;

- The MCO has failed to furnish any information requested by DHH regarding payments for providing goods or services;

- The MCO has made, or caused to be made, any false statement or representation of a material fact to DHH or CMS in connection with the administration of the Contract;

- The MCO has furnished goods or services to a member which at the sole discretion of DHH, and based on competent medical judgment and evaluation are determined to be 1) insufficient for his or her needs, 2) harmful to the member, or 3) of grossly inferior quality.

21.3. Sanction Types

The types of intermediate sanctions that DHH may impose on the MCO shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u-2) and 42 CFR §438.702-708 and may include any of the following:

- Civil monetary penalties in the amounts specified in 42 CFR §438.704

- Appointment of temporary management for an MCO as provided in 42 CFR §438.706;

- Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll;

- Suspension of all new enrollments, including automatic assignment, after the effective date of the sanction;

- Suspension of payment for members enrolled after the effective date of the sanction and until CMS or DHH is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur in accordance with 42 CFR §438.730; and

- Additional sanctions allowed under state statutes or regulations that address areas of noncompliance described above.

- DHH may require the MCO to develop a Corrective Action Plan, as described in Section 20.2, to address areas of non-compliance subject to intermediate sanctions.

- Except as provided in Section 21.6.3 before imposing any intermediate sanctions, DHH shall give the MCO timely written notice that explains the basis and nature of the sanction and any other due process protections.

21.4. Notice to CMS

DHH will give the CMS Regional Office written notice whenever it imposes or lifts an intermediate sanction for one of the violations listed in §438.700, specifying the affected MCO, the kind of sanction, and the reason for DHH's decision to lift a sanction. Notice will be given no later than thirty (30) days after DHH imposes or lifts the sanction.

21.5. Payment of Monetary Penalties and Sanctions

21.5.1. Monetary penalties or sanctions assessed by DHH that cannot be collected through the withhold specified in Section 5.3 shall be due and payable to DHH within thirty (30) calendar days after the MCO's receipt of the notice of monetary penalties or sanctions.

21.5.2. In the event an appeal by the MCO results in a decision in favor of the MCO, the amount specified in the decision will be returned to the MCO.

21.5.3. DHH has the right to recovery of any amounts overpaid as the result of deceptive practices by the MCO and/or its contractors, and may consider trebled damages, civil penalties, and/or other remedial measures.

21.5.4. A monetary penalty or sanction may be applied to all known affiliates, subsidiaries and parents of an MCO, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the MCO is affiliated where such conduct was accomplished within the course of his official duty or was effectuated by him with the knowledge or approval of such person.

21.6. Termination of MCO Contract

21.6.1. Nothing in this Section shall limit DHH's right to terminate the Contract or to pursue any other legal or equitable remedies.

21.6.2. Pursuant to 42 CFR §438.708, DHH may terminate the Contract and enroll that MCO's members in other MCOs or provide their benefits through other options included in the state plan if DHH, at its sole discretion, determines that the MCO has failed to: (1) carry out the substantive terms of the Contract, or (2) meet applicable requirements in Sections 1932, 1903(m) or 1905(t) of the Social Security Act.

21.6.3. DHH will provide the MCO with a timely written Notice of Intent to Terminate (Notice) that states the nature and basis of the penalty or sanction and pre-termination hearing rights.

21.6.4. The termination will be effective no less than thirty (30) calendar days from the date of the Notice of Intent to Terminate. The MCO may, at the discretion of DHH, be allowed to correct the deficiencies within the thirty (30) calendar day notice period, unless other provisions in this Section demand otherwise, prior to the issuance of a Notice of Termination.

21.6.5. In accordance with 42 CFR §438.710, DHH will conduct a pre-termination hearing upon the request of the MCO as outlined in the Notice to provide MCO the opportunity to contest the nature and basis of the sanction.

21.6.5.1. The request must be submitted in writing to the Undersecretary prior to the determined date of termination stated in the Notice.

21.6.5.2. The MCO shall receive a written notice of the outcome of the pre-termination hearing, if applicable, indicating decision reversal or affirmation.

21.6.6. The decision by the DHH Undersecretary shall be final and La.R.S. 49:950-999.25, the Administrative Procedure Act, does not apply. The Notice of Termination will state the effective date of termination.

21.6.7. DHH will notify the Medicaid members enrolled in the MCO in writing, consistent with 42 CFR §438.710 and §438.722, of the affirming termination decision and of their options for receiving Medicaid services and to disenroll immediately without cause.

21.7. Payment of Outstanding Monies or Collections from MCO

The MCO will be paid for any outstanding monies due less any assessed monetary penalties or sanctions. If monetary penalties exceed monies due, collection can be made from the MCO Fidelity Bond, Performance Bond, Retainage, Errors and Omissions Insurance, or any insurance policy or policies required under this Contract. The rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

21.8. Provider Sanctions

Nothing contained herein shall prohibit DHH from imposing sanctions, including civil monetary penalties, license revocation and Medicaid termination, upon a health care provider for its violations of federal or state law, rule, or regulations.

21.9. Independent Assurances

DHH will also require the Contractor and/or subcontractors, if performing a key internal control, to submit to an independent SSAE 16 SOC 1 and/or type II audit of its internal controls and other financial and performance audits from outside companies to assure both the financial viability of the (outsourced) program and the operational viability, including the policies and procedures placed into operation. The audit firm will conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. When required by DHH, the contractor must provide a quality control

plan, such as third party Quality Assurance (QA), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits.

21.9.1. These audits will require the Contractor to provide any assistance, records access, information system access, staff access, and space access to the party selected to perform the independent audit. The audit firm will submit to the State Agency and/or Contractor a final report on controls placed in operations for the project and includes a detailed description of the audit firm's tests of the operating effectiveness of controls.

21.9.2. The Contractor shall supply the Department with an exact copy of the report within thirty (30) calendar days of completion. When required by Office of Public Health, such audits may be performed annually during the term of the contract. The Contractor shall agree to implement recommendations as suggested by the audits within three months of report issuance at no cost to the State. If cost of the audit is to be borne by the Contractor, it was included in the response to the RFP.

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22.0 PROPOSAL AND EVALUATION

22.1. General Information

This Section outlines the provisions which govern determination of compliance of each proposer's response to the RFP.

22.1.1. DHH shall determine, at its sole discretion, whether or not the requirements have been reasonably met.

22.1.2. Omissions of required information shall be grounds for rejection of the proposal by DHH.

22.2. Blackout Period

The Blackout Period is a specified period of time during a competitive sealed procurement process in which any proposer, bidder, or its agent or representative, is prohibited from communicating with any state employee or contractor of the State involved in any step in the procurement process about the affected procurement. The Blackout Period applies not only to state employees, but also to any contractor of the State. "Involvement" in the procurement process includes but may not be limited to project management, design, development, implementation, procurement management, development of specifications, and evaluation of proposals for a particular procurement. All solicitations for competitive sealed procurements will identify a designated contact person. All communications to and from potential proposers, bidders, vendors and/or their representatives during the Blackout Period must be in accordance with this solicitation's defined method of communication with the designated contact person. The Blackout Period will begin upon posting of the solicitation. The Blackout Period will end when the contract is awarded.

In those instances in which a prospective vendor is also an incumbent vendor, the State and the incumbent vendor may contact each other with respect to the existing contract only. Under no circumstances may the State and the incumbent vendor and/or its representative(s) discuss the blacked-out procurement.

Any bidder, proposer, or state contractor who violates the Blackout Period may be liable to the State in damages and/or subject to any other remedy allowed by law.

Any costs associated with cancellation or termination will be the responsibility of the proposer or bidder.

Notwithstanding the foregoing, the Blackout Period shall not apply to:

- A protest to a solicitation submitted pursuant to La. R.S. 39:1671 or LAC 34:V.145.A.8;
- Duly noticed site visits and/or conferences for bidders or proposers;
- Oral presentations during the evaluation process; and
- Communications regarding a particular solicitation between any person and staff of the procuring agency provided the communication is limited strictly to matters of procedure. Procedural matters include deadlines for decisions or submission of proposals and the proper means of communicating regarding the procurement, but

shall not include any substantive matter related to the particular procurement or requirements of the RFP.

22.3. Rejection and Cancellation

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

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

22.4. Code of Ethics

Proposers are responsible for determining that there will be no conflict or violation of the Ethics Code if their company is awarded a contract. The Louisiana Board of Ethics is the only entity which can officially rule on ethics issues. Each proposal must include a statement signed by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract guaranteeing that there will be no conflict or violation of the Ethics Code if the Proposer is awarded a contract.

22.5. Award Without Discussion

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

22.6. Assignments

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

22.7. Proposer Prohibition

A proposer shall not submit multiple proposals in different forms. This restriction does not prohibit different proposers from offering the same subcontractor as a part of their proposals, provided that the subcontractor does not also submit a proposal as a prime contractor and the subcontractor has the capacity to provide services as a subcontractor to two prime contractors.

22.8. Determination of Responsibility

22.8.1. Determination of the proposer's responsibility relating to this RFP shall be made according to the standards set forth in LAC 34:V.136. The State must find that the selected proposer:

22.8.1.1. Has adequate financial resources for performance, or has the ability to obtain such resources as required during performance;

22.8.1.2. Has the necessary experience, organization, technical qualifications, skills, and facilities, or has the ability to obtain them;

22.8.1.3. Is able to comply with the proposed or required time of delivery or performance schedule; Has a satisfactory record of integrity, judgment, and performance; and

22.8.1.4. Is otherwise qualified and eligible to receive an award under applicable laws and regulations.

22.8.2. Proposers should ensure that their proposals contain sufficient information for the State to make its determination by presenting acceptable evidence of the above to perform the contracted services.

22.9. Proposal and Contract Preparation Costs

The proposer assumes sole responsibility for any and all costs and incidental expenses associated with the preparation and reproduction of any proposal submitted in response to this RFP. The proposer to which the contract is awarded assumes sole responsibility for any and all costs and incidental expenses that it may incur in connection with: (1) the preparation, drafting or negotiation of the final contract; or (2) any activities that the proposer may undertake in preparation for, or in anticipation or expectation of, the performance of its work under the contract before the contract receives final approval from the Division of Administration, Office of Contractual Review. The proposer shall not include these costs or any portion thereof in the proposed contract cost. The proposer is fully responsible for all preparation costs associated therewith even if an award is made but subsequently terminated by the Department.

22.10. Ownership of Proposal

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

22.11. Procurement Library/Resources Available To Proposer

22.11.1. Electronic copies of material relevant to this RFP will be posted at the following web addresses:

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

http://www.makingmedicaidbetter.com; and

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

22.11.2. Potential proposers may receive historical Medicaid claims data at the parish of residence level for SFY 12 and SFY 13 for MCO core benefits and services as well as pharmacy data, for mandatory and voluntary MCO populations under the following conditions:

22.11.2.1. Submit the non-binding Letter of Intent to Propose to the RFP Coordinator;

22.11.2.2. Sign and submit the **MCO Data Use Agreement** (Appendix P) to the RFP Coordinator; and

22.11.2.3. Mail or deliver to the RFP Coordinator listed in Section 1.4 a computer flash drive or hard drive with a capacity of at least 16GB on which to load the historic claims data, along with the name and address to which DHH will mail the data via first class mail, return receipt requested. Alternatively, provide the name of the person who will be picking up and signing for the data from the RFP Coordinator at the DHH Bienville Building, 628 North 4th Street , 5th Floor, Baton Rouge, LA . The storage drive and request for routing should be routed to the RFP Coordinator (See Section 1.4.1).

22.11.2.4. The claims data that is loaded onto the flash drive or hard drive will be password protected. DHH will give the password to the potential proposer by some means separate from the delivery of the flash drive or hard drive, such as by mail, fax, or telephone call.

22.11.2.5. The historical Medicaid claims data will be in SAS7BDAT format.

22.12. Proposal Submission

22.12.1. All proposals must be received by the due date and time indicated on the Schedule of Events. Proposals received after the due date and time will not be considered. It is the sole responsibility of each proposer to assure that its proposal is delivered at the specified location prior to the deadline. Proposals which, for any reason, are not so delivered will not be considered.

22.12.2. The Proposer shall submit one (1) original hard copy and two (2) additional hard copies of each proposal. Two (2) electronic copies of the proposal, each on a separate flash drive or CD(s) shall be submitted. No facsimile or emailed proposals will be accepted. Proposer should provide one electronic copy of the Redacted version (cd or flash drive).

22.12.3. The evaluation team will utilize both the hard copies and the electronic copy to evaluate the proposal. It is the proposer's responsibility to assure that all copies are complete and contain all required components for the evaluation.

22.12.4. Proposals must be submitted via U.S. mail, courier or hand delivered to:

If courier mail or hand delivered:

Mary Fuentes
Department of Health and Hospitals

Division of Contracts and Procurement Support
628 N 4th Street, 5th Floor
Baton Rouge, LA 70802

If delivered via US Mail:

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

22.13. Proprietary and/or Confidential Information

22.13.1. The designation of certain information as trade secrets and/or privileged or confidential proprietary information is applicable to this proposal. Any proposal copyrighted or marked as confidential or proprietary in its entirety may be rejected without further consideration or recourse.

22.13.2. For the purposes of this RFP, the provisions of the Louisiana Public Records Act (La.R.S. 44:1, et seq.) will be in effect. Pursuant to this Act, all proceedings, records, contracts, and other public documents relating to this RFP shall be open to public inspection. Proposers are reminded that while trade secrets and other proprietary information submitted in conjunction with this RFP may not be subject to public disclosure, protections must be claimed by the proposer at the time of submission of its proposal. Proposers should refer to the Louisiana Public Records Act for further clarification.

22.13.3. The proposer must clearly designate the part of the proposal that contains a trade secret and/or privileged or confidential proprietary information as "confidential" in order to claim protection, if any, from disclosure. The proposer shall mark the cover sheet of the proposal with the following legend, specifying the specific section(s) of the proposal sought to be restricted in accordance with the conditions of the legend: "The data contained in pages _____ of the proposal have been submitted in confidence and contain trade secrets and/or privileged or confidential information and such data shall only be disclosed for evaluation purposes, provided that if a contract is awarded to this proposer as a result of or in connection with the submission of this proposal, the state of Louisiana shall have the right to use or disclose the data therein to the extent provided in the contract. This restriction does not limit the state of Louisiana's right to use or disclose data obtained from any source, including the proposer, without restrictions."

22.13.4. Further, to protect such data, each page containing such data shall be specifically identified and marked **"CONFIDENTIAL."**

22.13.5. Proposers must be prepared to defend the reasons why the material should be held confidential. If a competing proposer or other person seeks review or copies of another proposer's confidential data, DHH will notify the owner of the asserted data of the request. If the owner of the asserted data does not want the information disclosed, it must take legal action as necessary to restrain DHH from releasing information DHH believes to be public record.

22.13.6. If the proposal contains confidential information, a redacted copy of the proposal must be submitted. If a redacted copy is not submitted, DHH may consider the entire proposal to be public record. When submitting the redacted copy, it should be clearly marked on the cover as - "**REDACTED COPY."** The redacted copy should also state which section(s) or information has been removed.

22.13.7 Any proposal marked as confidential or proprietary in its entirety may be rejected without further consideration or recourse. Additionally, any proposal that fails to follow this sections and/or La. R.S. 44:3.2(D)(1) shall have failed to properly assert the designation of trade secrets and/or privileged or confidential proprietary information and the information may be considered public records.

22.14. Errors and Omissions

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

22.15. Proposal Clarifications

The Department reserves the right to seek clarification of any proposal for the purpose of identifying and eliminating minor irregularities or informalities, including resolving inadequate proposal content, or contradictory statements in a proposer's proposal.

22.16. Interpretive Conventions

22.16.1. Whenever the terms "must," or "is required" are used in this RFP in conjunction with a specification or performance requirement, the specification or requirement is mandatory. A proposer's failure to address or meet any mandatory requirement in a proposal may be cause for DHH's rejection of the proposal.

22.16.2. Whenever the terms "can," "may," or "should" are used in this RFP in conjunction with a specification or performance requirement, the specification or performance requirement is a desirable, but not mandatory, requirement. Accordingly, a proposer's failure to address or provide any items so referred to will not be the cause for rejection of the proposal, but will likely result in a less favorable evaluation.

22.17. Proposal Content

22.17.1. The proposal shall address all requirements listed in Appendix KK **MCO Proposal Submission and Evaluation Requirements** of this RFP and should provide, in sequence, the information and documentation as required. The Proposer shall also complete the form provided in Appendix KK and include the completed form as the table of contents of the proposal.

22.17.2. Proposals should address how the proposer intends to assume complete responsibility for timely performance of all contractual responsibilities in accordance with federal and state laws, regulations, policies, and procedures.

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

22.17.4. The Proposer may not submit the Proposer's own contract terms and conditions or other requirements in a response to this RFP.

22.17.5. The Proposer must submit an original, signed Certification Statement (see Appendix A). The signed Certification Statement should be included in your response to Part I: Mandatory Requirements Section A.1. (see Appendix KK).

22.18. Proposal Format

22.18.1. Each proposal should be economically prepared, with emphasis on completeness and clarity of content. A proposal, as well as any reference material presented, must be written in English and should be typed on standard 8 1/2" x 11" paper with recommended margins of one inch. It should be single spaced with text no smaller than 11-point font; pages may be single sided or double sided. All proposal pages should be numbered and identified with the Proposer's name. Materials should be sequentially filed in three ring binders no larger than three inches in thickness.

22.18.2. The specific requirements and for making a Proposal in response to this RFP are detailed in **Appendix KK – MCO Proposal Submission and Evaluation Requirements**.

22.18.3. All information included in a Proposal should be relevant to a specific requirement detailed in the RFP and Appendix KK. All information should be incorporated into a response to a specific requirement and clearly referenced.

22.18.4. The Proposer should duplicate the Appendix KK ***MCO Proposal Submission and Evaluation Requirements*** form and use as the Table of Contents of each binder. The response to each Part and Section should be clearly labeled and tabbed.

22.18.5. The response to the **Appendix KK Part I. Mandatory Requirements** must be in a separate binder and clearly labeled. The response to Appendix KK Part II. Financial Requirements must be in a separate binder and clearly labeled. The response to Appendix KK Part IX. Veteran Initiative and Hudson Initiative must be in a separate binder and clearly labeled.

22.18.6. The response Parts III. through X. can be in the same binder or multiple binders as needed, but each Part and Section should be separated by an appropriately labeled tab.

22.18.7. Attachments should only be provided as requested in the ***MCO Proposal Submission and Evaluation Requirements*** and should be clearly labeled, including the Section number from the Requirements. Any information not meeting these criteria will be deemed extraneous.

22.19. Evaluation Criteria

The following criteria will be used to evaluate proposals:

22.19.1. The DHH Proposal Review Team will be comprised of state employees.

22.19.2. Proposal Review Team members will be required to sign disclosure forms to establish that they have no personal or financial interest in the outcome of the proposal review and contractor selection process.

22.19.3. Each Proposal Evaluation Team member shall evaluate each proposal against the evaluation criteria in this RFP as specified in Appendix KK, rather than against other proposals, and scoring will be done by consensus of the PRT assigned to each Section.

22.19.4. Proposals containing assumptions, lack of sufficient detail, poor organization, lack of proofreading and unnecessary use of self-promotional claims will be evaluated accordingly.

22.19.5. DHH reserves the right, at its sole discretion, to request Proposer clarification of a Proposal provision or to conduct clarification discussions with any or all Proposers. Any such clarification or discussion shall be limited to specific Sections of the proposal identified by DHH. The subject Proposer shall put any resulting clarification in writing as may be required by DHH.

22.19.6. DHH reserves the right, at its sole discretion, to conduct its own research and/or consult with contracted subject matter experts in order to verify and assess the information presented.

22.19.7. Scoring will be based on a possible total of 1,000-points, and the three (3) to five (5) proposals with the highest total scores may be recommended for award.

22.20 Administrative and Mandatory Screening

All proposals will be reviewed to determine compliance with administrative and mandatory requirements as specified in the RFP. Proposals that are not in compliance will be excluded from further consideration.

22.21 Withdrawal of Proposal

A proposer may withdraw a proposal that has been submitted at any time up to the date and time the proposal is due. To accomplish this, a written request signed by the authorized representative of the proposer must be submitted to the RFP Coordinator.

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23.0 EVALUATION CATEGORIES AND MAXIMUM POINTS

In the evaluation of proposals, DHH will consider each of the factors in the table below, which shows the maximum points that can be awarded for each category. There will be a maximum of 1,000 points available.

Ten percent (10%) of the total evaluation points for this RFP are reserved for proposers who are themselves a certified Veteran or Hudson Initiative small entrepreneurship or who will engage the participation of one or more certified Veteran or Hudson Initiatives small entrepreneurships as subcontractors (see Appendix D.)

Proposer Status and Reserved Points:

Reserved points shall be added to the applicable proposers' evaluation score as follows:

i. Proposer is a certified small entrepreneurship: Full amount of the reserved points

ii. Proposer is not a certified small entrepreneurship but has engaged one or more certified small entrepreneurships to participate as subcontractors or distributors. Points will be allocated based on the following criteria:

- The number of certified small entrepreneurships to be utilized
- The experience and qualifications of the certified small entrepreneurship(s)
- The anticipated earnings to accrue to the certified small entrepreneurship(s)

Evaluation Components	Possible Points
Part I. Mandatory Requirements	Included/not included
Part II. Financial Requirements	35
Part. III Organizational Requirements	85
Part IV. Provider Network	70
Part V. Member Management	220
Part VI. Marketing and Member Materials	30
Part VII. Quality Management	75
Part VIII. Program Integrity	60
Part IX. Systems and Technical Requirements	100
Part X. Added Value to Louisiana Members and Providers	225
Part XI. Veteran/Hudson Initiative	100
Total Possible Points	**1,000**

23.1 Announcement of Awards

DHH will recommend contract awards to between three and five proposers with the highest graded proposals and that are deemed to be in the best interest of DHH. DHH reserves the right not to award a contract or award fewer than three (3) contracts.

23.2 Notice of Contract Awards

The notice of intended contract award shall be sent by carriers that require signature upon receipt, by fax with voice confirmation, or by email with reply confirmation to the winning proposers. No proposer shall infer or be construed to have any rights or

interest to a contract with DHH until both the proposer and DHH have executed a valid contract and final approval is received from all necessary entities.

23.2.1. The State will notify the successful Proposer and proceed to negotiate terms for final contract. Unsuccessful proposers will be notified in writing accordingly.

23.2.2. The proposals received (except for that information appropriately designated as confidential in accordance with R.S. 44.1 et seq), selection memorandum along with list of criteria used along with the weight assigned each criteria; scores of each proposal considered along with overall scores of each proposal considered, and a narrative justifying selection shall be made available, upon request, to all interested parties after the "Notice of Intent to Award" letter has been issued.

23.2.3. Any Proposer aggrieved by the proposed award has the right to submit a protest in writing to the head of the agency issuing the proposal within 14 days after the award has been announced by the agency.

23.2.4. The award of a contract is subject to the approval of the Division of Administration, Office of Contractual Review.

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24.0 TURNOVER REQUIREMENTS

24.1 Introduction

Turnover is defined as those activities that the MCO is required to perform upon termination of the Contract in situations in which the MCO must transition contract operations to DHH or a third party. The turnover requirements in this Section are applicable upon any termination of the Contract 1) initiated by the MCO, 2) initiated by DHH, or 3) at the expiration of the Contract period and any extensions.

24.2 General Turnover Requirements

In the event the Contract is terminated for any reason, the MCO shall:

24.2.1. Comply with all terms and conditions stipulated in the Contract, including continuation of core benefits and services under the Contract, until the termination effective date;

24.2.2. Promptly supply all information necessary for the reimbursement of any outstanding claims; and

24.2.3. Comply with direction provided by DHH to assist in the orderly transition of equipment, services, software, leases, etc. to DHH or a third party designated by DHH.

24.3. Turnover Plan

24.3.1. In the event of written notification of termination of the Contract by either party, the MCO shall submit a Turnover Plan within thirty (30) calendar days from the date of notification, unless other appropriate timeframes have been mutually agreed upon by both the MCO and DHH. The Plan shall address the turnover of records and information maintained by the MCO relative to core benefits and services provided to Medicaid members. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by DHH.

24.3.2. If the Contract is not terminated by written notification as provided in 22.3.1 above, the MCO shall propose a Turnover Plan six months prior to the end of the Contract period, including any extensions to such period. The Plan shall address the possible turnover of the records and information maintained to either DHH or a third party designated by DHH. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by DHH.

24.3.3. As part of the Turnover Plan, the MCO must provide DHH with copies of all relevant member and core benefits and services data, documentation, or other pertinent information necessary, as determined by DHH, for DHH or a subsequent MCO to assume the operational activities successfully. This includes correspondence, documentation of ongoing outstanding issues, and other operations support documentation. The Plan will describe the MCO's approach and schedule for transfer of all data and operational support information, as

applicable. The information must be supplied in media and format specified by DHH and according to the schedule approved by DHH.

24.4. Transfer of Data

The MCO shall transfer all data regarding the provision of member core benefits and services to DHH or a third party, at the sole discretion of DHH and as directed by DHH. All transferred data must be compliant with HIPAA.

All relevant data must be received and verified by DHH or the subsequent MCO. If DHH determines that not all of the data regarding the provision of member core benefits and services to members was transferred to DHH or the subsequent MCO, as required, or the data is not HIPAA compliant, DHH reserves the right to hire an independent contractor to assist DHH in obtaining and transferring all the required data and to ensure that all the data are HIPAA compliant. The reasonable cost of providing these services will be the responsibility of the MCO.

24.5. Post-Turnover Services

Thirty (30) days following turnover of operations, the MCO must provide DHH with a Turnover Results report documenting the completion and results of each step of the Turnover Plan. Turnover will not be considered complete until this document is approved by DHH.

If the MCO does not provide the required relevant data and reference tables, documentation, or other pertinent information necessary for DHH or the subsequent MCO to assume the operational activities successfully, the MCO agrees to reimburse DHH for all reasonable costs, including, but not limited to, transportation, lodging, and subsistence for all state and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, reproduction and transfer functions at the location(s) of such records.

The MCO also must pay any and all additional costs incurred by DHH that are the result of the MCO's failure to provide the requested records, data or documentation within the time frames agreed to in the Turnover Plan.

The MCO must maintain all files and records related to members and providers for six (6) years after the date of final payment under the Contract or until the resolution of all litigation, claims, financial management review or audit pertaining to the Contract, whichever is longer. The MCO agrees to repay any valid, undisputed audit exceptions taken by DHH in any audit of the Contract.

24.6. Transition to Managed Long-Term Supports and Services

It is the state's intent to enter into a managed care contract(s) which shall offer holistic healthcare to dual eligible members and members requiring long-term supports and services, including behavioral health services. The MCO shall cooperate with any transition of populations or services to other healthcare delivery systems.

The MCO shall be responsible for coordinating with the new contractor for any records or service management data required for the transition of members and services to and from the new contractor's systems and care management.

Transitions may result in the loss of Per Member Per Month (PMPM) payments to the MCO for members transitioning out of the Bayou Health into the new system of care for long-term supports and services and may result in adjustments to the monthly capitated rate in order to maintain an actuarially sound rate range.

The MCO shall adhere to all transition requirements provided by DHH upon implementation of any new managed care contract(s).

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25.0 TERMS AND CONDITIONS

The Contract effective date is anticipated to be February 1, 2015. DHH reserves the right to revise the anticipated effective date and/or dates of the enrollment phases to a later date. DHH will provide the Contractor sixty (60) days prior notice of such change to provide the Contractor the opportunity to prepare for the on-site Readiness Review.

The term of the contract shall be thirty-six (36) months from the effective date or unless terminated prior to that date in accordance with state or federal law or terms of the Contract.

The MCO shall successfully complete a readiness review as specified in Section 19.2 of this RFP prior to the effective date in the time frame specified by the Department. If the MCO does not pass the readiness review the Contract shall be terminated by DHH.

Subject to Section 25.1 of this RFP, with all proper approvals and concurrence with the successful contractor, DHH may also exercise an option to extend for up to twenty-four (24) additional months at the same rates, terms and conditions of the initial contract term. Subsequent to the extension of the contract beyond the initial 36 month term, prior approval by the Joint Legislative Committee on the Budget (JLCB) or other approval authorized by law shall be obtained. Such written evidence of JLCB approval shall be submitted, along with the contract amendment to the Office of Contractual Review (OCR) to extend contract terms beyond the initial 3 year term.

The MCO agrees to comply with all state and federal laws, regulations, and policies as they exist or as amended that are or may be applicable to this Contract, not specifically mentioned in this Section, including those in the DHH pro forma contract (Appendix B). Any provision of this Contract which is in conflict with federal statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal policy. Such amendment of the contract will be effective on the effective date of the statutes, regulations, or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties. The MCO may request DHH to make policy determinations required for proper performance of the services under this Contract.

Statements, acts and omissions made by or on behalf of the Commissioner of Administration regarding this RFP, any proposer and/or any subcontractor of a proposer shall not be deemed a conflict of interest when the Commissioner is discharging her duties and responsibilities under law, including, but not limited, to the Commissioner of Administration's authority in procurement matters.

25.1 Amendments

The Contract may be amended at any time as provided in this paragraph. The Contract may be amended whenever appropriate to comply with state and federal requirements or state budget reductions; provided, however, that rates must be certified as actuarially sound. No modification or change of any provision of the Contract shall be made or construed to have been made unless such modification is mutually agreed to in writing by the MCO and DHH, and incorporated as a written amendment to the Contract. Any amendment to the Contract shall require approval by DHH, the Division of Administration Office of Contractual Review and may require approval of the CMS Regional Office prior to the amendment implementation.

DHH reserves the right to provide written clarification for non-material changes of

contract requirements whenever deemed necessary, at any point in the contract period, to ensure the smooth operations of the Bayou Health Program. Such clarifications shall be implemented by the MCO and will not require an amendment to the Contract.

25.2 Applicable Laws and Regulations

25.2.1 The MCO agrees to comply with all applicable federal and state laws and regulations including Constitutional provisions regarding due process and equal protection under the laws and including, but not limited to:

25.2.1.1. Title 42, Code of Federal Regulations (CFR), Chapter IV, Subchapter C (Medical Assistance Programs);

25.2.1.2. All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 (42 U.S.C. §7401, et seq.) the Clean water Act (33 U.S.C. §1251 et seq.) and 20 U.S.C. §6082(2) of the Pro-Children Act of 1994 (P.L. 103-227);

25.2.1.3. Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d) and regulations issued pursuant thereto, 45 CFR Part 80; In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d, et seq.) and its implementing regulations at 45 CFR Part 80, the MCO must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Contract;

25.2.1.4. Title VII of the Civil Rights Act of 1964 (42 U.S.C. §2000e) in regard to employees or applicants for employment;

25.2.1.5. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84;

25.2.1.6. The Age Discrimination Act of 1975, 42 U.S.C. §6101 et seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance;

25.2.1.7. The Omnibus Budget Reconciliation Act of 1981, P.L.97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance;

25.2.1.8. The Balanced Budget Act of 1997, P.L. 105-33 and the Balanced Budget Refinement Act of 1999, P.L. 106-113;

25.2.1.9. The Americans with Disabilities Act, 42 U.S.C. §12101 et seq., and regulations issued pursuant thereto;

25.2.1.10. Sections 1128 and 1156 of the Social Security Act, relating to exclusion of MCOs for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

25.2.1.11. The Federal Drug Free Workplace Act of 1988, P.L. 100-690, as implemented in 45 CFR Part 82;

25.2.1.12. Title IX of the Education Amendments of 1972 regarding education programs and activities;

25.2.1.13. The Byrd Anti-Lobbying Amendment Contractors who apply or bid shall file the require certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. §1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier-to-tier up to the recipient (45 CFR §3).

25.2.1.14. The Equal Opportunity Act of 1972;

25.2.1.15. Federal Executive Order 11246;

25.2.1.16. The Federal Rehabilitation Act of 1973;

25.2.1.17. The Vietnam Era Veteran's Readjustment Assistance Act of 1974;

25.2.1.18. Title IX of the Education Amendments of 1972;

25.2.1.19. The Age Act of 1975; and

25.2.1.20. The Americans with Disabilities Act of 1990.

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

25.2.2 Notwithstanding Section 2.4 of this RFP, the contractor agrees not to discriminate in its employment practices, and will render services under this contract without regard to race, color, religion, sex, national origin, veteran status, political affiliation, or disabilities. Any act of discrimination committed by Contractor, or failure to comply with these statutory obligations when applicable shall be grounds for termination of this contract.

25.3 Assessment of Fees

The Contractor and DHH agree that DHH may elect to deduct any assessed fees from payments due or owing to the MCO or direct the MCO to make payment directly to DHH for any and all assessed fees. The choice is solely and strictly DHH's choice.

The Contractor shall be responsible for payment of all premium taxes paid through the capitation payments by DHH to the Louisiana Department of Insurance according to the schedule established by DHH.

25.4 Attorney's Fees

In the event DHH should prevail in any legal action arising out of the performance or non-performance of the Contract, the MCO shall pay, in addition to any monetary penalties, all expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

25.5 Board Resolution/Signature Authority

The MCO, if a corporation, shall secure and attach to the Contract a formal Board Resolution indicating the signatory to the Contract is a corporate representative and authorized to sign said Contract.

25.6 Confidentiality of Information

25.6.1 All financial, statistical, personal, technical and other data and information relating to the State's operation which are designated confidential by DHH and made available to the contractor in order to carry out this contract, or which become available to the contractor in carrying out this contract, shall be protected by the contractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to DHH. The identification of all such confidential data and information as well as DHH's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by DHH in writing to the contractor. If the methods and procedures employed by the contractor for the protection of the contractor's data and information are deemed by DHH to be adequate for the protection of DHH's confidential information, such methods and procedures may be used, with the written consent of DHH, to carry out the intent of this paragraph. The contractor shall not be required under the provisions of the paragraph to keep confidential any data or information which is or becomes publicly available, is already rightfully in the contractor's possession, is independently developed by the contractor outside the scope of the contract, or is rightfully obtained from third parties.

25.6.2 Under no circumstance shall the contractor discuss and/or release information to the media concerning this project without prior express written approval of the Department of Health and Hospitals.

25.6.3 The MCO shall assure that medical records and any and all other health and enrollment information an relating to members or potential members, which is provided to or obtained by or through the MCO's performance under this Contract, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under 45 CFR Parts 160 and 164 (the HIPAA Privacy Rule) and other state and federal laws, DHH policies or this Contract. The MCO shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Contract.

25.6.4 All information as to personal facts and circumstances concerning members or potential members obtained by the MCO shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of DHH or the member/potential member, unless otherwise permitted by HIPPA or required by applicable State or federal law regulations, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of this Contract.

25.7 Conflict of Interest

The MCO may not contract with Louisiana Medicaid unless such safeguards at least equal to federal safeguards (41 U.S.C. §423) are in place per state Medicaid Director letter dated December 30, 1997 and §1932(d)(3) of the Social Security Act, addressing 1932 State Plan Amendment and the default enrollment process under the State Plan Amendment option.

25.8 Contract Controversies

Any claim or controversy arising out of the contract shall be resolved by the provisions of Louisiana Revised Statutes 39:1524-26.

25.9 Contract Language Interpretation

Subject to Section 25.31 of the RFP, the MCO and DHH agree that in the event of a disagreement regarding, arising out of, or related to, Contract language interpretation, DHH's interpretation of the Contract language in dispute shall control and govern.

25.10 Cooperation with Other Contractors

25.10.1 In the event that DHH has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder including but not limited to fiscal intermediary and enrollment broker services, the MCO agrees to cooperate fully with such other contractors. The MCO shall not commit any act that will interfere with the performance of work by any other contractor.

25.10.2 The MCO's failure to cooperate and comply with this provision shall be sufficient grounds for DHH to halt all payments due or owing to the MCO until it becomes compliant with this or any other contract provision. DHH's determination on the matter shall be conclusive and not subject to appeal.

25.11 Copyrights

If any copyrightable material is developed in the course of or under this Contract, DHH shall have a royalty free, non-exclusive, and irrevocable right to reproduce, publish, or otherwise use the work for DHH purposes.

25.12 Corporation Requirements

If the MCO is a corporation, the following requirement must be met prior to execution of the Contract:

25.12.1 If a for profit corporation whose stock is not publicly traded-the MCO must file a Disclosure of Ownership form with the Louisiana Secretary of State.

25.12.2 If the MCO is a corporation not incorporated under the laws of the state of Louisiana-the MCO must obtain a Certificate of Authority pursuant to R.S. 12:301-302 from the Louisiana Secretary of State.

25.12.3 The MCO must provide written assurance to DHH from the MCO's legal counsel that the MCO is not prohibited by its articles of incorporation, bylaws or the laws under which it is incorporated from performing the services required under the Contract.

25.13 Debarment/Suspension/Exclusion

25.13.1 The MCO agrees to comply with all applicable provisions of 2 CFR Part 376, pertaining to nonprocurement debarment and/or suspension. As a condition of enrollment, the MCO must screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or all federal health care programs. To help make this determination, the MCO may search the following websites:
Office of Inspector General (OIG) List of Excluded Individuals/Entities) LEIE https://oig.hhs.gov/exclusions/index.asp;

the Health Integrity and Protection Data Bank (HIPDB)
http://www.npdb-hipdb.hrsa.gov/index.jsp;

the Louisiana Adverse Actions List Search (LAALS)
https://adverseactions.dhh.la.gov ;

and/or the System for Award Management, http://www.sam.gov.

25.13.2 The MCO shall conduct a screen, as described in Section 25.13~~2~~.1 monthly to capture exclusions and reinstatements that have occurred since the last search and any exclusion information discovered should be immediately reported to DHH. Any individual or entity that employs or subcontracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against providers who employ or enter into provider contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR §1003.102(a)(2).

25.14 Effect of Termination on MCO's HIPAA Privacy Requirements

25.14.1 Upon termination of this Contract for any reason, the MCO shall return or destroy all Protected Health Information received from DHH, or created or received by

the MCO on behalf of DHH. This provision shall also apply to Protected Health Information that is in the possession of subcontractors or agents of the MCO. The MCO shall not retain any copies of the Protected Health Information.

25.14.2 In the event that the MCO determines that returning or destroying the Protected Health Information is not feasible, the MCO shall provide to DHH notification of the conditions that make return or destruction not feasible. Upon a mutual determination that return or destruction of Protected Health Information is not feasible, the MCO shall extend the protections of the Contract to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction not feasible, for so long as the MCO maintains such Protected Health Information.

25.15 Emergency Management Plan

25.15.1 The MCO shall submit an emergency management plan within forty-five (45) days from the date the Contract is signed to DHH for approval. The emergency management plan shall specify actions the MCO shall conduct to ensure the ongoing provision of health services in an epidemic, disaster or manmade emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies. Revisions to the DHH approved emergency plan shall be submitted to DHH for approval no less than 30 days prior to implementation of requested changes. The MCO shall submit an annual certification (from the date of the most recently approved plan) to DHH certifying that the emergency plan is unchanged from the previously approved plan.

25.15.2 At a minimum, the plan should include the elements contained in the ***Emergency Management Plan*** in Appendix OO.

25.16 Employee Education about False Claims Recovery

If the MCO receives annual Medicaid payments of at least $5,000,000, the MCO must comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005.

25.17 Employment of Personnel

25.17.1 In all hiring or employment made possible by or resulting from this Contract, the MCO agrees that:

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

- Affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all applicable state and federal laws regarding employment of personnel.

25.17.2 This requirement shall apply to, but not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training including apprenticeship. The MCO further agrees to give public notice in conspicuous places available to employees and applicants for employment

setting forth the provisions of this Section. All solicitations or advertisements for employees shall state that all qualified applicants will receive consideration for employment without regard to handicap, age, race, color, religion, sex, or national origin. All inquiries made to the MCO concerning employment shall be answered without regard to handicap, age, race, color, religion, sex, or national origin. All responses to inquiries made to the MCO concerning employment made possible as a result of this Contract shall conform to federal, state, and local regulations.

25.18 Entire Contract

This Contract, together with the RFP and addenda issued thereto by DHH, the proposal submitted by the proposer in response to DHH's RFP, and any exhibits specifically incorporated herein by reference constitute the entire agreement between the parties with respect to the subject matter.

The MCO shall comply with all provisions of the Contract and shall act in good faith in the performance of the provisions of said Contract. The MCO shall be bound by all applicable Department issued guides. The MCO agrees that failure to comply with the provisions of the Contract may result in the assessment of monetary penalties, sanctions and/or termination of the Contract in whole or in part, as set forth in the Contract. The MCO shall comply with all applicable DHH policies and procedures in effect throughout the duration of the Contract period. The MCO shall comply with all applicable DHH provider manuals, rules and regulations and guides.

DHH, at its discretion, will issue correspondence to inform the MCO of changes in Medicaid policies and procedures which may affect the Contract. Unless otherwise specified in the Medicaid correspondence the MCO will be given sixty (60) calendar days to implement such changes.

25.19 Force Majeure

The MCO and DHH may be excused from performance under this Contract for any period they may be prevented from performance by an Act of God; strike, war, civil disturbance or court order. The MCO shall, however, be responsible for the development and implementation of an Emergency Management Plan as specified in Section 25.14 of this RFP.

25.20 Fraudulent Activity

25.20.1 The MCO shall report to DHH any cases of suspected Medicaid fraud or abuse by its members, network providers, employees, or subcontractors. The MCO shall report such suspected fraud or abuse in writing as soon as practical after discovering suspected incidents, but no more than three (3) business days. The MCO shall report the following fraud and abuse information to DHH:

- The number of complaints of fraud and abuse made to the MCO that warrant preliminary investigation; and
- For each case of suspected provider fraud and abuse that warrants a full investigation:
    - the provider's name and number

- the source of the complaint
- the type of provider
- the nature of the complaint
- the approximate range of dollars involved
- the legal and administrative disposition of the case

25.20.2 The MCO shall adhere to the policy and process contained in this RFP for referral of cases and coordination with DHH for fraud and abuse complaints regarding members and providers.

25.21 Governing Law and Place of Suit

It is mutually understood and agreed that this Contract shall be governed by the laws of the state of Louisiana, except its conflict of laws provisions, as to both interpretation and performance. Any administrative proceeding, action at law, suit in equity, or judicial proceeding for the enforcement of this Contract or any provision thereof shall be instituted only in the administrative tribunals and courts of the state of Louisiana. Specifically, any state court suit shall be filed in the 19th Judicial District Court for East Baton Rouge Parish as the exclusive venue for same, and any federal suit shall be filed in the U.S. District Court for the Middle District of Louisiana as the exclusive venue for same. This Section shall not be construed as granting a right or cause of action to the MCO in any of the aforementioned Courts.

25.22 HIPAA Business Associate

Individually identifiable health information is to be protected in accordance with the rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as agreed upon in the HIPAA Business Associate Addendum, Appendix C.

25.23 Confidentiality~~HIPAA~~ Compliance

25.23.1 The MCO shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (the HITECH Act) and the rules and regulations promulgated there under (45 CFR Parts 160, 162, and 164). The MCO shall ensure compliance with all HIPAA requirements across all systems and services related to this Contract, including transaction, common identifier, and privacy and security standards, by the effective date of those rules and regulations.

25.23.2 Confidentiality of Alcohol and Drug Abuse Patient Records

- The MCO shall agree to comply with the Drug Abuse Prevention, Treatment and Rehabilitation Act; the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, and applicable sections of the Public Health Service Act, codified at 42. U.S.C. 290dd-2 ("the Privacy Statute"). MCO shall also agree to strictly maintain the confidentiality of patient records of drug, alcohol, and other drug treatment programs in addition to treatment and assessment for pathological or compulsive gambling. MCO shall agree to comply with the Privacy Statute and any of its current and future accompanying regulations (42 CFR Part 2).

- The MCO shall ensure that every individual treated by a 42 CFR covered provider is offered to sign a consent form for the disclosure of substance use treatment information to the individual's PCP for the purpose of healthcare integration in accordance with 42 CFR Part 2, Subpart C.

- The MCO shall have the ability to track provider compliance with offering consent forms for members receiving substance use services by 42 CFR covered providers, including the number of members receiving substance use services by provider and the number of consent forms offered and signed. The MCO shall report this information to DHH upon request.

- The MCO shall educate contracted providers on protocols for requesting and receiving patient records in accordance with 45 CFR Part 160 and 42 CFR Part 2.

- Disclosures of substance use information without written consent by the patient must be compliant with 42 CFR Part 2.

- Disclosures of substance use information must be accompanied by a statement prohibiting re-disclosure.

- MCO shall develop policies and procedures which outline HIPAA requirements and 42 CFR Part 2 requirements for the purpose of healthcare integration. These policies and procedures shall outline instances in which 42 CFR Part 2 overrides HIPAA requirements.

25.23.3 HIPAA Disclosure Process

MCOs shall protect confidential information and documents in accordance with 42 USC §671(a)(8), 42 USC §5106a, 42 USC §290dd-2, 45 CFR §1355.21, 45 CFR §205.50, 45 CFR §1355.30, 42 CFR Part 2, La.R.S. 46:56, and 45 CFR Parts 160 and 164, as applicable.

MCOs are required to submit incident reports affecting providers or member receiving services to DHH with a corrective action plan and timelines for implementation of correction for approval by DHH within three (3) days of MCO discovery of any HIPAA violation, breach or use or disclosure of PHI as defined in 45 CFR §164.402, or potential violation, breach, or disclosure within three (3) days of DHH notifying the MCO of a HIPAA violation, breach, use, or disclosure of PHI as defined in 45 CFR §164.402 or potential violation, breach, or disclosure. The incident report shall include, at a minimum:

- Date of discovery;
- Date or date range of violation/potential violation;
- Cause of the incident including sequence and mechanisms;
- Number of unauthorized individuals who viewed PHI;
- Number of affected individuals whose PHI was compromised;
- Steps taken to correct this incident to date, and planned steps to correct incident;

- Steps taken to prevent reoccurrence from happening in the future;
- Steps taken to mitigate any harmful effects caused by the unauthorized disclosure;
- Any training or other corrective action targeted to the MCOs;
- Staff or providers subsequent to this incident;
- Plans for notification of CMS/HHS; and,
- Notification plan to individuals.
- A risk assessment which includes the following:
    - The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
    - The unauthorized person who used the PHI or to whom the disclosure was made;
    - Whether the PHI was actually acquired or viewed; and
    - The extent to which the risk to the PHI has been mitigated.

25.24 Hold Harmless

25.24.1 The MCO shall indemnify, defend, protect, and hold harmless DHH and any of its officers, agents, and employees from:

- Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for the MCO in connection with the performance of this Contract;
- Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by MCO, its agents, officers, employees, or subcontractors in the performance of this Contract;
- Any claims for damages or losses resulting to any person or firm injured or damaged by the MCO, its agents, officers, employees, or subcontractors by MCO's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Contract in a manner not authorized by the Contract or by federal or state regulations or statutes;
- Any failure of the MCO, its agents, officers, employees, or subcontractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;
- Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of DHH in connection with the defense of claims for such injuries, losses, claims, or damages specified above; and
- Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHH or their

agents, officers or employees, through the intentional conduct, negligence or omission of the MCO, its agents, officers, employees or subcontractors.

25.24.2 In the event of circumstances not reasonably within the control of the MCO or DHH, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither the MCO, DHH, or any subcontractor(s), will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered services. Notwithstanding, as long as this Contract remains in full force and effect, the MCO shall be liable for the core benefits and services required to be provided or arranged for in accordance with this Contract.

25.24.3 DHH will provide prompt notice of any claim against it that is subject to indemnification by MCO under this Contract. The MCO may, at its sole option, assume the defense of any such claim. DHH may not settle any claim subject to indemnification hereunder without the advance written consent of MCO, which shall not be unreasonably withheld.

25.25 Hold Harmless as to the MCO Members

25.25.1 The MCO hereby agrees not to bill, charge, collect a deposit from, seek cost sharing or other forms of compensation, remuneration or reimbursement from, or have recourse against, MCO members, or persons acting on their behalf, for health care services which are rendered to such members by the MCO and its subcontractors, and which are core benefits and services.

25.25.2 The MCO further agrees that the MCO member shall not be held liable for payment for core benefits and services furnished under a provider contract, referral, or other arrangement, to the extent that those payments would be in excess of the amount that the member would owe if the MCO provided the service directly. The MCO agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by MCO and insolvency of the MCO.

25.25.3 The MCO further agrees that the MCO member shall not be held liable for the costs of any and all services provided by a provider whose service is not covered by the MCO or does not obtain timely approval or required prior-authorization.

25.25.4 The MCO further agrees that this provision shall be construed to be for the benefit of MCO members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the MCO and such members, or persons acting on their behalf.

25.26 Homeland Security Considerations

25.26.1 The MCO shall perform the services to be provided under this Contract entirely within the United States. The term “United States” includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the MCO will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

25.26.2 If the MCO performs services, or uses services, in violation of the foregoing paragraph, the MCO shall be in material breach of this Contract and shall be liable to DHH for any costs, fees, damages, claims, or expenses it may incur. Additionally, the MCO shall be required to hold harmless and indemnify DHH pursuant to the indemnification provisions of this Contract.

25.26.3 The prohibitions in this Section shall also apply to any and all agents and subcontractors used by the MCO to perform any services under this Contract.

25.27 Incorporation of Schedules/Appendices

All schedules/appendices referred to in this RFP are attached hereto, are expressly made a part hereof, and are incorporated as if fully set forth herein.

25.28 Independent Provider

It is expressly agreed that the MCO and any subcontractors and agents, officers, and employees of the MCO or any subcontractors in the performance of this Contract shall act in an independent capacity and not as officers, agents, express or implied, or employees of DHH or the state of Louisiana. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the MCO or any subcontractor and DHH and the state of Louisiana.

25.29 Integration

This Contract and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. The MCO also agrees to be bound by the Contract and any rules or regulations that may be promulgated. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or affect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved by the parties.

25.30 Interest

Interest generated through investments made by the MCO under this Contract shall be the property of the MCO and shall be used at the MCO's discretion.

25.31 Interpretation Dispute Resolution Procedure

25.31.1 The MCO may request in writing an interpretation of the issues relating to the Contract from the Medicaid MCO Program Director. In the event the MCO disputes the interpretation by the Medicaid MCO Program Director, the MCO shall submit a written reconsideration request to the Medicaid Director.

25.31.2 The MCO shall submit, within twenty-one (21) days of said interpretation, a written request disputing the interpretation directly to the Medicaid Director. The ability to dispute an interpretation does not apply to language in the Contract that is based on federal or state statute, regulation or case law.

25.31.3 The Medicaid Director shall reduce the decision to writing and provide a copy to the MCO. The written decision of the Medicaid Director shall be the final decision

of DHH. The Medicaid Director will render his final decision based upon the written submission of the MCO and the Medicaid MCO Program Director, unless, at the sole discretion of the Medicaid Director, the Medicaid Director allows an oral presentation by the MCO and the Medicaid MCO Program Director or his/her designee. If such a presentation is allowed, the information presented will be considered in rendering the decision.

25.31.4 Pending final determination of any dispute over a DHH decision, the MCO shall proceed diligently with the performance of the Contract and in accordance with the direction of DHH.

25.32 Loss of Federal Financial Participation (FFP)

The MCO hereby agrees to be liable for any loss of FFP suffered by DHH due to the MCO's, or its subcontractors', failure to perform the services as required under this Contract. Payments provided for under this Contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR §438.730.

25.33 Misuse of Symbols, Emblems, or Names in Reference to Medicaid

No person or MCO may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems the words “Louisiana Medicaid,” or “Department of Health and Hospitals” or “Bureau of Health Services Financing,” unless prior written approval is obtained from DHH. Specific written authorization from DHH is required to reproduce, reprint, or distribute any DHH form, application, or publication for a fee. State and local governments are exempt from this prohibition. A disclaimer that accompanies the inappropriate use of program or DHH terms does not provide a defense. Each piece of mail or information constitutes a violation.

25.34 National Provider Identifier (NPI)

The HIPAA Standard Unique Health Identifier regulations (45 CFR Part 162, Subparts A & D) require that all covered entities (health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES).

25.35 Non-Discrimination

In accordance with 42 CFR §438.6 (d)(3) and (4), the MCO shall not discriminate in the enrollment of Medicaid individuals into the MCO. The MCO agrees that no person, on the grounds of handicap, age, race, color, religion, sex, national origin, or basis of health status or need for health care services shall be excluded from participation in, or be denied benefits of the MCO’s program or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the MCO. The MCO shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts.

25.36 Non-Waiver of Breach

The failure of DHH at any time to require performance by the MCO of any provision of this Contract, or the continued payment of the MCO by DHH, shall in no way affect the right of DHH to enforce any provision of this Contract; nor shall the waiver of any breach of any provision thereof be taken or held to be a waiver of any succeeding breach of such provision or as a waiver of the provision itself. No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract shall be waived except by the written agreement of the parties and approval of CMS, if applicable. Waiver of any breach of any term or condition in this Contract shall not be deemed a waiver of any prior or subsequent breach. No term or condition of this Contract shall be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties hereto.

25.37 Offer of Gratuities

By signing this Contract, the MCO signifies that no member of, or a delegate of, Congress, nor any elected or appointed official or employee of the state of Louisiana, the Government Accountability Office, DHHS, CMS, or any other federal agency has or shall benefit financially or materially from this Contract. This Contract may be terminated by DHH if it is determined that gratuities of any kind were offered to, or received by, any officials or employees from the state, its agents, or employees.

25.38 Order of Precedence

In the event of any inconsistency or conflict among the document elements of this Contract, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

- The body of the Contract with exhibits and attachments, excluding the RFP and the contractor's proposal;
- This RFP and any addenda and appendices;
- MCO Systems Companion Guide;
- MCO Quality Companion Guide; and
- The Proposal submitted by the MCO in response to this RFP.

25.39 Physician Incentive Plans

25.39.1 The MCO shall comply with requirements for physician incentive plans, as required by 42 CFR §438.6(h) and set forth (for Medicare) in 42 CFR §422.208 and §422.210.

25.39.2 Assurances to CMS. Each organization will provide to DHH assurance satisfactory to the Secretary of HHS that the requirements of §422.208 are met.

25.40 Political Activity

None of the funds, materials, property, or services provided directly or indirectly under this Contract shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the "Hatch Act".

25.41 Prohibited Payments

Payment for the following shall not be made:

- Organ transplants, unless the state plan has written standards meeting coverage guidelines specified;
- Non-emergency services provided by or under the direction of an excluded individual;
- Any amount expended for which funds may not used under the Assisted Suicide Funding Restriction Act of 1997;
- Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a state plan; and
- Any amount expended for home health care services unless the MCO provides the appropriate surety bond.

25.42 Rate Adjustments

The MCO and DHH both agree that the monthly capitation rates identified in this RFP shall be in effect during the period identified on the MCO Rate Schedule that will be posted on DHH's website. Rates may be adjusted during the Contract period based on DHH and actuarial analysis, subject to CMS review and approval.

The MCO and DHH both agree that the adjustments to the monthly capitation rate(s) required pursuant to this Section shall occur only by written amendment to the Contract. Should the MCO refuse to accept the revised monthly capitation rate, Section 25.63 of the RFP and the provisions of the RFP for contract turnover and performance bond shall apply.

25.43 Record Retention for Awards to Recipients

Financial records, supporting documents, statistical records, and all other records pertinent to an award shall be retained for a period of six (6) years from the date of submission of the final expenditure report, or for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report. The only exceptions are the following:

- If any litigation, claim , financial management review, or audit is started before the expiration of the six (6) year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken;
- Records for real property and equipment acquired with federal funds shall be retained for six (6) years after final disposition;
- When records are transferred to or maintained by DHH, the six (6) year retention requirement is not applicable to the recipient; and
- Indirect cost rate proposals, cost allocations plans, etc., as specified in 45 CFR §74.53(g).

25.44 References to Statutes, Rules, or Regulations

All references in this RFP to any statute, rule, or regulation shall be deemed to refer to the provisions of the statute, rule, or regulation as they exist at the time of the issuance of this RFP or as they may be hereafter amended. At any given time, the MCO shall comply with the provisions that are currently in effect at that time.

25.45 Release of Records

The MCO shall release medical records upon request by members or authorized representative, as may be directed by authorized personnel of DHH, appropriate agencies of the state of Louisiana, or the United States Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in this Contract. The ownership and procedure for release of medical records shall be controlled by the Louisiana revised statutes, including but not limited to, La. R.S. 40:1299.96, La.R.S. 13:3734, and La.C.Ev. Art. 510; and 45 CFR Parts 160 and 164 (HIPAA Privacy Rule) and subject to reasonable charges. The MCO shall not charge DHH/BHSF or their designated agent for any copies of records requested.

25.46 Reporting Changes

The MCO shall immediately notify DHH of any of the following:

- Change in business address, telephone number, facsimile number, and e-mail address;
- Change in corporate status or nature;
- Change in business location;
- Change in solvency;
- Change in corporate officers, executive employees, or corporate structure;
- Change in ownership, including but not limited to the new owner's legal name, business address, telephone number, facsimile number, and e-mail address;
- Change in incorporation status;
- Change in federal employee identification number or federal tax identification number; or
- Change in MCO litigation history, current litigation, audits and other government investigations both in Louisiana and in other states.

25.47 Right to Audit

The State Legislative Auditor, agency, and/or federal auditors and internal auditors of the Division of Administration shall have the option to audit all accounts directly pertaining to the contract for a period of three (3) years from the date of the last payment made under this contract. Records shall be made available during normal working hours for this purpose.

25.48 Safeguarding Information

The MCO shall establish written safeguards which restrict the use and disclosure of information concerning members or potential members to purposes directly connected with the performance of this Contract. The MCO's written safeguards shall:

- Be comparable to those imposed upon the DHH by 42 CFR Part 431, Subpart F, and La. R.S. 46:56;
- State that the MCO will identify and comply with any stricter state or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;
- Require a written authorization from the member or potential member before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR §164.508;
- Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and
- Specify appropriate personnel actions to sanction violators.

25.49 Safety Precautions

DHH assumes no responsibility with respect to accidents, illnesses or claims arising out of any activity performed under this Contract. The MCO shall take necessary steps to ensure or protect its members, itself, and its personnel. The MCO agrees to comply with all applicable local, state, and federal occupational and safety acts, rules, and regulations.

25.50 Severability

If any provision of this Contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void by a judgment or order of a court of competent jurisdiction, then both DHH and MCO shall be relieved of all obligations arising under such provision. If the remainder of this Contract is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed. In addition, if the laws or regulations governing this Contract should be amended or judicially interpreted as to render the fulfillment of the Contract impossible or economically infeasible, both DHH and the MCO will be discharged from further obligations created under the terms of the Contract.

25.51 Software Reporting Requirement

All reports submitted to DHH by the MCO must be in format accessible and modifiable by the standard Microsoft Office Suite of products, Version 2007 or later, or in a format accepted and approved by DHH.

25.52 Termination for Convenience

DHH may terminate this Contract for convenience and without cause upon sixty (60) calendar days written notice. DHH shall not be responsible to the MCO or any other party for any costs, expenses, or damages occasioned by said termination, i.e., this termination is without penalty.

25.53 Termination Due to Serious Threat to Health of Members

DHH may terminate this Contract immediately if it is determined that actions by the MCO or its subcontractor(s) pose a serious threat to the health of members enrolled in the MCO. The MCO members will be given an opportunity to enroll in another MCO (if there is capacity) or move to Medicaid fee-for-service.

25.54 Termination for MCO Insolvency, Bankruptcy, Instability of Funds

25.54.1. The MCO's insolvency or the filing of a petition in bankruptcy by or against the MCO shall constitute grounds for termination for cause. If DHH determines the MCO has become financially unstable, DHH will immediately terminate this Contract upon written notice to the MCO effective the close of business on the date specified.

25.54.2. The MCO shall cover continuation of services to members for the duration of any period for which payment has been made, as well as for inpatient admissions up until discharge.

25.55 Termination for Ownership Violations

The MCO is subject to termination, unless the MCO can demonstrate changes of ownership or control, when:

- A person with a direct or indirect ownership interest in the MCO:
  - Has been convicted of a criminal offense under §1128(a) or 1128(b)(1) or (b)(3) of the Social Security Act, in accordance with 42 CFR §1002.203;
  - Has had civil liquidated damages or assessment imposed under §1128A of the Social Security Act; or
  - Has been excluded from participation in Medicare or any state health care program.
- Any individual who has a direct or indirect ownership interest or any combination thereof of 5% or more, or who is an officer (if the MCO is organized as a corporation), or who is a partner (if it is organized as a partnership), or who is an agent or a managing employee, is under temporary management as defined in Section 21.3.
- The MCO has a direct or indirect substantial contractual relationship with an excluded individual or entity. “Substantial contractual relationship” is defined as any direct or indirect business transactions that amount in a single fiscal year to more than $25,000 or 5% of the MCO’s total operating expenses, whichever is less.

25.56 Termination for Unavailability of Funds

In the event that federal and/or state funds to finance this Contract become unavailable after the effective date of this Contract, or prior to the anticipated Contract expiration date, DHH may terminate the Contract without penalty. This notification will be made in writing. Availability of funds shall be determined solely by DHH.

Any Proposer has the duty to fully cooperate with the State and provide any and all requested information, documentation, etc. to the state when requested. This applies even if an eventual contract is terminated and/or a lawsuit is filed. Specifically, the proposer does not have the right to limit or impede the State’s right to audit or to withhold State owned documents.

25.57 Time is of the Essence

Time is of the essence in this Contract. Any reference to "days" shall be deemed calendar days unless otherwise specifically stated.

25.58 Titles

All titles used herein are for the purpose of clarification and shall not be construed to infer a contractual construction of language.

25.59 Use of Data

DHH shall have unlimited rights to use, disclose, or duplicate, for any purpose, all information and data developed, derived, documented, or furnished by the MCO resulting from this Contract.

25.60 Waiver of Administrative Informalities

The Department of Health and Hospitals reserves the right, at its sole discretion, to waive minor administrative informalities contained in any proposal.

25.61 Waiver

The waiver by DHH of any breach of any provision contained in this Contract shall not be deemed to be a waiver of such provision on any subsequent breach of the same or any other provision contained in this Contract and shall not establish a course of performance between the parties contradictory to the terms hereof.

25.62 Warranty to Comply with State and Federal Regulations

The MCO shall warrant that it shall comply with all state and federal laws and regulations as they exist at the time of the Contract or as subsequently amended.

25.63 Warranty of Removal of Conflict of Interest

The MCO shall warrant that it, its officers, and its employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services hereunder. The MCO shall periodically inquire of its officers and employees concerning such conflicts, and shall inform DHH promptly of any potential conflict. The MCO shall warrant that it shall remove any conflict of interest prior to signing the Contract.

25.64 Withholding in Last Month of Payment

During the transition to a new Contractor, for the last month of the Contract, the Department shall withhold seventy-five percent (75%) of the final payment to the Contractor for a maximum of ninety (90) days from the due date of such amount to ensure that the outgoing Contractor fulfills its contractual obligations and repays DHH for payments made on behalf of ineligible recipients, some of which may extend past the term of the Contract.

25.65 Termination for Failure to Accept Revised Monthly Capitation Rate

Should the MCO refuse to accept a revised monthly capitation rate as provided in Section 25.42~~40~~ of the RFP, it may request DHH in writing to permit the Contract to

be terminated effective at least sixty (60) calendar days from the date of DHH's receipt of the written request. DHH shall have sole discretion to approve or deny the request for termination and to impose such conditions on the granting of an approval as it may deem appropriate, but it shall not unreasonably withhold its approval.

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1915(b) Waivers - one of several options available to states that allow the use of Managed Care in the Medicaid Program. When using 1915(b), states have four different options:

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

1915(c) Waivers - one of many options available to states to allow the provision of long term care services in home and community based settings under the Medicaid Program. States can offer a variety of services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

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

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medicaid program.

Action – The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service, the failure to provide services in a timely manner as defined by Sections 7.3 and 7.5 of this RFP; or the failure of the MCO to act within the timeframes provided in Section 13.7.1 of this RFP.

Actuarially Sound PMPM rates – PMPM rates that (1) have been developed in accordance with generally accepted actuarial principles and practices; (2) are appropriate for the populations to be covered, and the services to be furnished under the Contract; and (3) have been certified, as meeting the requirements of this definition, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

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

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

Adequate Network/Adequacy of Network – Refers to the network of health care providers for an MCO that is sufficient in numbers and types of providers and facilities to ensure that all services are accessible to members without unreasonable delay. Adequacy is determined by a number of factors, including but not limited to, provider-patient ratios for primary care providers; geographic accessibility and travel distance; waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments and hours of provider operations.

Adjudicate – means to deny or pay a clean claim.

Adjustments to Smooth Data – Adjustments made, by cost-neutral methods, across rate cells, to compensate for distortions in costs, utilization, or the number of eligibles.

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

Adverse Action – Any decision by the MCO to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested.

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

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

(1) owns or holds more than a five percent (5%) interest in the MCO (either directly, or through one (1) or more intermediaries);
(2) in which the MCO owns or holds more than a five percent (5%) interest (either directly, or through one (1) or more intermediaries);
(3) any parent entity or subsidiary entity of the MCO regardless of the organizational structure of the entity;
(4) any entity that has a common parent with the MCO (either directly, or through one (1) or more intermediaries);
(5) any entity that directly, or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, the MCO; or
(6) any entity that would be considered to be an affiliate by any Securities and Exchange Commission (SEC) or Internal Revenue Service (IRS) regulation, Federal Acquisition Regulations (FAR), or by another applicable regulatory body.

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

Aged/Blind/Disabled – means the categories of individuals who meet the Medicaid eligibility factor of age, blindness, or a mental and/or physical disability.

Agent – An entity that contracts with DHH to perform administrative functions, including but not limited to fiscal intermediary activities, outreach, eligibility, and enrollment activities, systems and technical support, etc.

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

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

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

Appeal – A request for a review of an action.

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

Automatic Assignment – The process utilized to enroll into an MCO, using predetermined algorithms, a Medicaid eligible that (1) is not excluded from MCO participation and (2) does not proactively select an MCO within the DHH specified timeframe.

Basic Behavioral Health Services – Mental health and substance abuse services which are provided to enrollees with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders that are provided in the enrollee's PCP office by the enrollee's PCP as part of primary care service activities.

Benefits or Covered Services – Those health care services to which an eligible Medicaid recipient is entitled under Louisiana Medicaid State Plan.

Blocked Call – A call that cannot be connected immediately because no circuit is available at the time the call arrives or the telephone system is programmed to block calls from entering the queue when the queue backs up beyond a defined threshold.

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

Business Continuity Plan (BCP) – means a plan that provides for a quick and smooth restoration of MIS operations after a disruptive event. BCP includes business impact analysis, BCP development, testing, awareness, training, and maintenance. This is a day-to-day plan.

Business Day – Traditional workdays, including Monday, Tuesday, Wednesday, Thursday and Friday. State holidays are excluded and traditional work hours are 8:00 a.m. – 5:00 p.m.**,** unless the context clearly indicates otherwise.

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

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

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

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

Capitation – A contractual agreement through which the MCO agrees to provide specified core health benefits and services to members for a fixed amount per month.

Capitation Payment – A payment, fixed in advance, that DHH makes to an MCO for each member covered under the Contract for the provision of core health benefits and services and assigned to the MCO. This payment is made regardless of whether the member receives core benefits and services during the period covered by the payment.

Capitation Rate – The fixed monthly amount that the MCO is prepaid by DHH for each member assigned to the MCO to ensure that core benefits and services under this Contract are provided.

Capitated Service – Any core benefit or service for which the MCO receives an actuarially sound capitation payment.

Care Coordination – Deliberate organization of patient care activities by a person or entity formally designated as primarily responsible for coordinating services furnished by providers involved in the member's care to facilitate care within the network with services provided by non-network providers to ensure appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of member's care.

Care Management – Overall system of medical management encompassing Utilization Management, Referral, Case Management, Care Coordination, Continuity of Care and Transition Care, Chronic Care Management, Quality Care Management, and Independent Review.

Case Management – Refers to a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a member's needs through communication and available resources to promote high quality, cost-effective outcomes. Case management services are defined as services provided by qualified staff to a targeted population to assist them in gaining timely access to the full range of needed services including medical, social, educational, and other support services. Case Management services include an individual needs assessment and diagnostic assessment, individual treatment plan development, establishment of treatment objectives, and monitoring outcomes.

Case Manager – A person who is either a degreed social worker, licensed registered nurse, or a person with a minimum of two years experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities. Case management manager shall not provide direct care services to members enrolled with the Contractor, but shall authorize appropriate services and/or refer members to appropriate services.

Cause – Specified reasons that allow mandatorily enrolled MCO members to change their MCO choice. Term may also be referred to as "good cause."

Centers for Disease Control/Advisory Committee on Immunization Practices (CDC/ACIP) – Federal agency and committee whose role is to provide advice that will lead to a reduction in the incidence of vaccine-preventable diseases in the United States and an increase in the safe use of vaccines and related biological products.

Centers for Medicare and Medicaid Services (CMS) – The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act. Formerly known as Health Care Financing Administration (HCFA).

Certified Nurse Midwife (CNM) – An advanced practice registered nurse educated in the disciplines of nursing and midwifery and certified according to a nationally recognized certifying body, such as the American College of Nurse Midwives Certification Council, as approved by the state board of nursing and who is authorized to manage the nurse midwifery care of newborns and women in the ante-partum, intra-partum, postpartum, and/or gynecological periods.

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

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

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

Chronic Condition – persistent or frequently recurring conditions of significant duration that may limit an individual's activities and require ongoing medical care to optimize the individual's quality of life.

Chronic Care Management – The concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care.

Chronic Care Management Program (CCMP) – A program that provides care management and coordination of activities for individuals determined to be at risk for high medical costs.

Claim – means (1) a bill for services, (2) a line item of service, or (3) all services for one recipient within a bill.

Clean Claim –. A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Co-branding – a relationship between two or more separate legal entities, one of which is an MCO. The MCO's health plan displays the name(s) or brand(s) of the co-branding entity or entities on its marketing materials to signify a business arrangement. Co-branding arrangements allow

an MCO and its co-branding partner(s) to promote enrollment in the MCO's health plan. Co-branding relationships are entered into independent of the contract that the MCO has with DHH.

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

CommunityCARE 2.0 – Refers to the Louisiana Medicaid Primary Care Case Management (PCCM) program which links Medicaid eligibles to a primary care provider as their medical home.

Contract – The written agreement between DHH and the MCO; comprised of the RFP, Contract, any addenda, appendices, attachments, or amendments thereto.

Contract Dispute – A circumstance whereby the MCO and DHH or the MCO and their subcontractor are unable to arrive at a mutual interpretation of the requirements, limitations, or compensation for the performance of services under their contract.

Convicted – A judgment of conviction entered by a federal, state or local court, regardless of whether an appeal from that judgment is pending.

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

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

Co-payment – Any cost sharing payment for which the Medicaid MCO member is responsible, in accordance with 42 CFR §447.50 and Section 5006 of the American Recovery and Reinvestment Act (ARRA) for Native American members.

Core Benefits and Services – A schedule of health care benefits and services required to be provided by the MCO to Medicaid members as specified under the terms and conditions of this RFP and Contract and the Louisiana Medicaid State Plan.

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

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

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

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

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

Cost Ssettlement – Mechanism utilized within a cost based reimbursement system. The Medicaid claims are paid in the interim at a rate that approximates the actual cost of the claim. The actual final reimbursement is determined from the filed cost report and based on the cost reimbursement rules that are contained within the Medicaid State Plan.

Covered Services – Those health care services/benefits to which an individual eligible for Medicaid or CHIP is entitled under the Louisiana Medicaid State Plan.

Cultural Competency – A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Members. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

DHH Administrative Regions – The nine Louisiana geographic areas designated in state statute for administrative purposes. Each geographic area is comprised of specific parishes. For specific areas see:
http://www.dhh.louisiana.gov/offices/medialibrary/media-1/REG_MAP04.jpg

Deliverable – A document, manual, file, plan, or report submitted to DHH by the MCO to fulfill requirements of this Contract.

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

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

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

Disease Management (DM) – see Chronic Care Management

Disenrollment – The removal of a member from participation in the MCO's plan, but not necessarily from the Medicaid or LaCHIP Program.

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

Documented Attempt – A *bona fide*, or good faith, attempt, in writing, by the MCO to contract with a provider, made on or after the date the MCO signs the Contract with DHH. Such attempts may include written correspondence that outlines contract negotiations between the parties, including rate and contract terms disclosure. If, within 10 calendar days, the potential network

provider rejects the request or fails to respond either verbally or in writing, the MCO may consider the request for inclusion in the MCO's network denied by the provider. This shall constitute one attempt.

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

E-Consultation – The use of electronic computing and communication technologies in consultation processes.

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

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

Eligible – An individual determined eligible for assistance in accordance with the Medicaid State Plan(s) under Title XIX (Medicaid) or Title XXI (CHIP) of the Social Security Act.

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

Emergency Services – Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 CFR §438.114(a) and §1932(b)(2) of the Social Security Act and that are needed to screen, evaluate, and stabilize an emergency medical condition. Services defined as such under Section 1867 (e) of the Social Security Act ("anti-dumping provisions"). If an emergency medical condition exists, the MCO is obligated to pay for the emergency service. Coverage of emergency services must not include any prior authorization requirements and the "prudent layperson" standard shall apply to both in-plan and out-of-plan coverage.

Encounter – A distinct set of health care services provided to a Medicaid member enrolled with an MCO on the dates that the services were delivered.

Encounter Data – Health care encounter data include: (i) All data captured during the course of a single health care encounter that specify the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the member receiving services during the encounter; (ii) The identification of the member receiving and the provider(s) delivering the health care services during the single encounter; and, (iii) A unique, i.e. unduplicated, identifier for the single encounter.

Encounter Data Adjustment – Adjustments to encounter data that are allowable under the Medicaid Management Information System (MMIS) for HCFA 1500, UB-04, KM-3 and NCPDP version 3.2 claim forms as specified in the ***MCO Systems Companion Guide***.

Enrollee – Louisiana Medicaid or CHIP recipient who is currently enrolled in an MCO or other Medicaid managed care program.

Enrollment – The process conducted by the Enrollment Broker by which an eligible Medicaid recipient becomes a member of an MCO.

Enrollment Broker – The state's contracted or designated agent that performs functions related to choice counseling, enrollment and disenrollment of potential enrollees and enrollees into an MCO.

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

Excluded Populations – Medicaid eligibles who are excluded from enrollment in an MCO and may not voluntarily enroll.

Excluded Services – those services which members may obtain under the Louisiana Medicaid State Plan and for which the MCO is not financially responsible.

Expanded Services – A covered service provided by the MCO which is currently a non-covered service(s) in the Medicaid State Plan or is an additional Medicaid covered service furnished by the MCO to Medicaid MCO members for which the MCO receives no additional capitated payment, and is offered to members in accordance with the standards and other requirements set forth in the RFP.

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

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

External Quality Review Organization (EQRO) – an organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs EQR and other related activities as set forth in federal regulations, or both.

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

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

Federally Qualified Health Center (FQHC) – An entity that receives a grant under Section 330 of the Public Health Service Act (also see §1905(1)(2)(B) of the Social Security Act) to provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.

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

FFS Provider – An institution, facility, agency, person, corporation, partnership, or association approved by DHH which accepts payment in full for providing benefits, with the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

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

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

Fiscal Year (FY) – Federal Fiscal Year (FFY): October 1 through September 30; State Fiscal Year (SFY): July 1 through June 30.

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

Fraud – As relates to Medicaid Program Integrity, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received.

Full-Time Equivalent Position (FTE) – Refers to the equivalent of one (1) individual full-time employee who works forty (40) hours per week; or a full-time primary care provider shall be defined as a one delivering outpatient preventive and primary (routine, urgent and acute) care for twenty (20) hours or more per week (exclusive of travel time).

GEO Coding – Refers to the process in which implicit geographic data is converted into explicit or map-form images.

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

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

Go-Live Date – The date the MCO shall begin providing services to Medicaid members.

Good Cause – See "cause".

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

Grievance Process – The procedure for addressing enrollee's grievances.

Grievance System – A grievance process, an appeal process, and access to the State's fair hearing system. Any grievance system requirements apply to all three components of the grievance system not just to the grievance process.

Health Care Professional – A physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law. Other health care practitioner includes any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

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

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

Health Information Technology for Economic and Clinical Health Act (HITECH Act) Title IV – The legislation establishes a transparent and open process for the development of standards that will allow for the nationwide electronic exchange of information between doctors, hospitals, patients, health plans, the government and others by the end of 2009. It establishes a voluntary certification process for health information technology products. The National Institute of Standards and Technology will provide for the testing of such products to determine if they meet the national standards that allow for the secure electronic exchange and use of health information.

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

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

Historical Provider Relationship – The provider who has been the main source of Medicaid services for the member during the previous year (decided on by the most recent CommunityCARE 2.0 PCP, or if not previously enrolled in CommunityCARE 2.0, by the provider (PCP or specialist) in the previous 12 months with whom the member had the most visits.

Home and Community Based Services Waiver (HCBS) – Under Section 1915 (c) of the Social Security Act states may request waivers of state wideness, comparability of services, and community income and resource rules for the medically needy in order to develop Medicaid-financed community-based treatment alternatives. Non-state plan services that may be offered include case management, homemaker/home health aide services, personal care services, adult day health, habilitation, and respite care. Current HCBS waivers in Louisiana are New Opportunities Waiver (NOW), Children's Choice, Elderly and Disabled Adult Waiver, Adult Day Health Care, Supports Waiver, and Adult Residential Options.

Hospice – Services provided as described in Louisiana Medicaid State Plan and 42 CFR Part 418, which are provided to terminally ill individuals, with a prognosis of six (6) months or less, who elect to receive hospice services provided by a certified hospice agency.

ICD-9-CM codes – International Classification of Diseases, 9th Revision, Clinical Modification codes represent a uniform, international classification system of coding disease and injury diagnoses. This coding system arranges diseases and injuries into code categories according to established criteria. MCOs shall move to ICD-10-CM as it becomes effective.

IEP Services – These are therapies included in a student's Individualized Education Plan (IEP). Included are physical therapy, occupational therapy, speech/language therapy, audiology and some psychological therapy. The enrolled provider must be a public school system and they certify the state match via Certified Public Expenditures (CPE). The school board does bill fee-for-service through the MMIS claims payment system which acts as an interim payment. At the end of the year there is a cost settlement process.

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

Implementation Date – The date DHH notifies the MCO that Network Adequacy has been certified by DHH, the MCO has successfully completed the Readiness Review and is approved to begin enrolling members.

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

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

Individual Practice – Independent primary care providers who work in their own private practices.

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

Information Systems (IS) – A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or

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

Inpatient Facility – Hospital or clinic for treatment that requires at least one overnight stay.

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

Institutionalized – A patient in a nursing facility; an inpatient in a medical institution or institution for mental disease, whereby payment is based on a level of care provided in a nursing facility; or receives home and community-based waiver services.

Intermediate Sanctions – those actions authorized by 42 CFR §438.700, et seq. for certain actions or omissions by a managed care organization.

Investigational Procedure/Service – See Experimental Procedure/Service.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO/Joint Commission) – An organization that operates accreditation programs to subscriber hospitals and other healthcare organizations.

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

KIDMED – Louisiana's name for the screening component of the Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) program provided for Medicaid eligible children under the age of 21 as required by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89).

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

LaCHIP – Refers to the Louisiana's Medicaid expansion CHIP (Title XXI) Program that provides health coverage to uninsured children under age 19, whose families have a net income up to 200 percent of the Federal Poverty Level (FPL); and whose income exceeds the Medicaid limit. Phase I includes children ages 6-18 with income from 100% up to and including 133% FPL; Phase II includes children with income from 134% up to and including 150% FPL; Phase III includes children with income from 151% FPL up to and including 200% FPL; Phase IV provides prenatal coverage from conception to birth for children whose uninsured mothers are ineligible for Medicaid and have net family income at or below 200% FPL (referred to as the LaCHIP~~LaCHP~~ Prenatal Program); and Phase V includes children in families with income from 201% up to and including 250% FPL. LaCHIP Phase V (referred to as the LaCHIP Affordable Plan) is administered by the Louisiana Office of Group Benefits.

LaMOMS – Medicaid program for pregnant women with income up to and including 133% FPL and optional Medicaid program for pregnant women with income from 134% up to and including 185% FPL. With a 15% income disregard, the income limit is, in effect, 200% FPL. The program

provides pregnancy-related services, delivery and post-partum care for 60 days after the pregnancy ends for women whose sole basis of eligibility is pregnancy.

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

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

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

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

Local Governing Entity (LGE) – A system of independent healthcare districts and authorities. Within LGEs, services are provided through various arrangements including state operated, state contracted services, private comprehensive providers, rehabilitation agencies, community addiction and mental health clinics, Licensed Mental Health Professionals (LMHPs), and certified peer support specialists.

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

Louisiana Department of Health and Hospitals (DHH) – The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Louisiana.

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

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

Major Subcontract – means any contract, subcontract, or agreement between the MCO and another entity that meets any of the following criteria:

- the other entity is an affiliate of the MCO;
- the subcontract is considered by DHH to be for a key type of service or function, including:
    - o administrative services (including but not limited to third party administrator, network administration, and claims processing);
    - o delegated networks (including but not limited to vision)
    - o management services (including management agreements with parent)
    - o reinsurance;
    - o disease management;
    - o call lines (including nurse and medical consultation); or
    - o Any other subcontract that is, or is reasonably expected to be, more than $100,000 per year. Any subcontracts between the MCO and a single entity that are split into separate agreements by time period, etc., will be consolidated for the purpose of this definition.

For the purposes of this RFP, major subcontracts do not include contracts with any non-affiliates for any of the following, regardless of the value of the contract: utilities (e.g., water, electricity, telephone, Internet), mail/shipping, office space, or computer hardware.

Major Subcontractor – Means any entity with a major subcontract with the MCO. For the purposes of this Contract, major subcontractors do not include providers in the MCO's provider network. Major subcontractors may include, without limitation, affiliates, subsidiaries, and affiliated and unaffiliated third parties.

Managed Care Organization (MCO) – A private entity that contracts with DHH to provide core benefits and services to Louisiana Medicaid MCO Program enrollees in exchange for a monthly prepaid capitated amount per member. The entity is regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency, pursuant to La.R.S. 22:1016, but shall, solely with respect to its products and services offered pursuant to the Louisiana Medicaid Program be regulated by the Louisiana Department of Health and Hospitals.

Managed Care Program – Louisiana Medicaid program providing statewide leadership to most effectively utilize resources to promote the health and well-being of Louisianans in DHH's Bayou Health Program.

Mandatory Population/Enrollee – The groups of Medicaid eligibles who are required to enroll in a Medicaid MCO and whose participation is not voluntary.

Marketing – Means any communication, from an MCO to a Medicaid enrollee who is not enrolled in that MCO, that can reasonably be interpreted as intended to influence the recipient to enroll in that particular MCO's Medicaid product, or either to not enroll in, or to disenroll from, another MCO's Medicaid product.

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

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

Material Changes – Material changes are changes affecting the delivery of care or services provided under this RFP. Material changes include, but are not limited to, changes in composition

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

MCO Administrative Services – means the performance of services or functions, other than the direct delivery of core benefits and services, necessary for the management of the delivery of and payment for core benefits and services, including but not limited to network, utilization, clinical and/or quality management, service authorization, claims processing, management information systems operation, and reporting.

MCO Systems Companion Guide – A supplement to the Contract that outlines the formatting and reporting requirements concerning encounter data, interfaces between the FI and the MCO and enrollment broker and the MCO.

Measurable – Applies to an MCO objective and means the ability to determine definitively whether or not the objective has been met, or whether progress has been made toward a positive outcome.

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

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

Medicaid Eligible – An individual who has been determined eligible, pursuant to federal and state law, to receive medical care, goods or services for which DHH may make payments under the Medicaid or LaCHIP Program, who is currently enrolled in the Medicaid or LaCHIP Program, and on whose behalf payments may or may not have been made.

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

Medicaid Management Information System (MMIS) – Mechanized claims processing and information retrieval system which all states Medicaid programs are required to have and which must be approved by the Secretary of DHHS. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Enrollees.

Medicaid Recipient – An individual who has been determined eligible, pursuant to federal and state law, to receive medical care, goods or services for which DHH may make payments under the Medicaid or LaCHIP Program, who may or may not be currently enrolled in the Medicaid or LaCHIP Program**,** and on whose behalf payment has been made.

Medical Director – The licensed physician designated by the MCO to exercise general supervision over the provision of core benefits and services by the MCO.

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

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

Medical Loss Ratio – The percentage of PMPM payments received by the MCO from DHH used to pay medical claims from providers and approved quality improvement and IT costs.

Medical Loss Ratio Year – The calendar year for which Medical Loss Ratio is being reported.

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

Medical Screening – An examination: (1) provided on hospital property, and provided for that patient for whom it is requested or required, (2) performed within the capabilities of the hospital, and provided for that patient for whom it is requested or required, (3) the purpose of which is to determine whether the patient has an Emergency Medical Condition, and (4) performed by a physician (M.D. or D.O.) and/or by a nurse practitioner, or physician assistant as permitted by state statutes and regulations and hospital bylaws.

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

Medically Necessary Services – Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary." The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing services at his discretion on a case-by-case basis.

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

Member – As it relates to the Louisiana Medicaid Program and this RFP, refers to a Medicaid or CHIP eligible who enrolls in an MCO under the provisions of this RFP and also refers to "enrollee" as defined in 42 CFR §438.10(a).

Member Materials – Means all written materials produced or authorized by the MCO and distributed to members or potential members containing information concerning the MCO Program(s). Member materials include, but are not limited to, member ID cards, member handbooks, provider directories, and marketing materials.

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

Mental Health/Substance Abuse (MH/SA) providers – behavioral health professionals engaged in the treatment of substance abuse, dependency, addiction, or mental illness

Methodology – The planned process, steps, activities or actions taken by an MCO to achieve a goal or objective, or to progress toward a positive outcome.

Monetary Penalties – Monetary sanctions that may be assessed whenever an MCO, its providers, and/or its subcontractors fail to achieve certain performance standards and other items defined in the terms and conditions of the Contract.

Monitoring – The process of observing, evaluating, analyzing and conducting follow-up activities.

Must – Denotes a mandatory requirement.

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

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

Network – As utilized in the RFP, "network" may be defined as a group of participating providers linked through subcontractual arrangements to an MCO to supply a range of primary and acute health care services. Also referred to as Provider Network.

Network Adequacy – Refers to the network of health care providers for an MCO that is sufficient in numbers and types of providers and facilities to ensure that all services are accessible to members without unreasonable delay. Adequacy is determined by a number of factors, including but not limited to, provider patient ratios; geographic accessibility and travel distance; waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments and hours of provider operations.

Newborn – A live infant born to an MCO member.

Non-Contracting Provider – A person or entity that provides hospital or medical care but does not have a contract or agreement with the MCO.

Non-Covered Services – Services not covered under the Title XIX Louisiana State Medicaid Plan.

Non-Emergency – An encounter by an MCO member who has presentation of medical signs and symptoms, to a health care provider

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

Non-Participating Physician – A physician licensed to practice that has not contracted with or is not employed by the MCO to provide health care services.

Non-Urgent Sick Care – Medical care given for an acute onset of symptoms that is not emergent or urgent in nature. Examples of non-urgent sick visit include cold symptoms, sore throat, and nasal congestion; requires face-to-face medical attention within 48-72 hours of member notification of a non-urgent condition, as clinically indicated.

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

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

Open Panel – means PCPs who are accepting new patients for the Louisiana Medicaid MCO program.

Operational Start Date – Means the first day on which an MCO is responsible for providing core benefits and services to MCO members and all related Contract functions. The Operational start date may vary per MCO. The Operational Start Date(s) applicable to this Contract are set forth in the Contract between DHH and the MCO (Appendix B of this RFP).

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

Outlier – Additional payment that is made for catastrophic costs associated with services provided to 1) children under the age of six who received inpatient services in a disproportionate share hospital setting, and 2) infants who have not attained the age of one year who received inpatient services in any acute care setting.

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

Ownership Interest – The possession of stock, equity in the capital, or any interest in the profits of the MCO, for further definition see 42 CFR §455.101.

Per Member Per Month (PMPM) – The amount of money paid or received on a monthly basis for each individual enrolled in the MCO.

Performance Concern – The informal documentation of an issue. The MCO is required to respond to the performance concern by defining a process to detect, analyze and eliminate non-compliance and potential causes of non-compliance. This is a "warning" and failure to comply with the Corrective Action Plan and/or continued non-compliance may result in formal action against the MCO.

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

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

Permanent Supportive Housing (PSH) - Consists of deeply affordable, community-integrated rental housing combined with supportive services that are designed to assist households in gaining and maintaining access to safe, good quality housing. In PSH, the service recipient is the tenant and leasee. Tenancy is not contingent upon continued receipt of services. The State of Louisiana's PSH program serves low income households in which a member has a substantial long term disability.

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

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

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

Pharmacy Benefit Manager (PBM) – a third party administrator of prescription drug programs

Physician Assistant – A health care professional who is a graduate of a program accredited by the Committee on Allied Health Education and Accreditation or its successors and who has successfully passed the national certificate examination administered by the National Commission on the Certification of Physicians' Assistants or its predecessors and who is approved and licensed by the Louisiana State Board of Medical Examiners to perform medical services under the supervision of a physician or group of physicians who are licensed and registered with the board to supervise such assistant. A physician assistant may perform certain duties such as history taking, diagnosis, drawing blood samples, urinalysis, and injections under the supervision of a physician.

Physician Extender – Nurse practitioners, certified nurse mid-wives, and physician assistants linked to a physician group who provide primary care services.

Plan of Care – Strategies designed to guide health care professionals involved with patient care. Such plans are patient specific and are meant to address the total status of the patient. Care plans are intended to ensure optimal outcomes for patients during the course of their care.

PMPM Rate – The per-member, per-month rate paid to the MCO by DHH for the provision of medical services to MCO members.

Policies – The general principles by which DHH is guided in its management of the Title XIX program, and as further defined by DHH promulgations and by state and federal rules and regulations.

Post-Stabilization Care Services – Covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain, improve or resolve the member's condition pursuant to 42 CFR §422.113(c) and §422.114(e).

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

Poverty Level – Poverty guidelines issued annually in late January or early February of each year by HHS for the purpose of determining financial eligibility for certain programs including Medicaid and CHIP and which are based on household size.

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

Pre-Certification – Review conducted prior to a member's utilization of a l service or course of treatment in a hospital or other facility.

Preferred Drug List (PDL) – a list maintained by the MCO indicating which drugs providers are permitted to prescribe without seeking prior authorization.

Preventive Care – Refers to the treatment to avert disease/illness and/or its consequences. The term is used to designate prevention and early detection programs rather than restorative or treatment programs. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred; requires a face-to-face visit within 4 weeks of member request.

Primary Care Case Manager (PCCM) – A physician, physician group practice, or entity that employs or arranges with physicians to furnish primary care case management services.

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

Primary Care Services – Health care services and laboratory services customarily furnished by or through a primary care provider for diagnosis and treatment of acute and chronic illnesses,

disease prevention and screening, health maintenance, and health promotion either through, direct service to the member when possible, or through appropriate referral to specialists and/or ancillary providers.

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

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

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

Provider – Either (1) for the fee-for-service program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the MCO Program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers services.

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

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

Provider Directory – A listing of health care service providers under contract with the MCO that is prepared by the MCO as a reference tool to assist members in locating providers that are available to provide services.

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

Provider Subcontract – An agreement between an MCO and a provider of services to furnish core benefits and services to members, or with a marketing organization, or with any other organization or person who agrees to perform any administrative function or service for the MCO specifically related to fulfilling the MCO's obligations under the terms of this RFP.

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

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

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

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

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

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

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

Recipient – An individual entitled to benefits under Title XIX or Title XXI of the Social Security Act, and under the Louisiana Medicaid State Plan who is or was enrolled in Medicaid and on whose behalf a payment has been made for medical services rendered.

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

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

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

Reinsurance – Insurance an MCO purchases to protect itself against part or all of the losses incurred in the process of honoring the claims of members; also referred to as "stop loss" insurance coverage.

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

Relationship – Relationship is described as follows for the purposes of any business affiliations discussed in Section 5: A director, officer, or partner of the MCO; A person with beneficial ownership of five percent or more of the MCO's equity; or A person with an employment, consulting or other arrangement (e.g., providers) with the MCO obligations under its contract with the state.

Remittance Advice – An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only. Transactions may include but are not limited to, members enrolled in the MCO, payments for maternity, and adjustments.

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

Reprocessing (Claims) – Upon determination of the need to correct the outcome of one or more claims processing transactions, the subsequent attempt to process a single claim or batch of claims.

Responsible Party – An individual, often the head of household, who is authorized to make decisions and act on behalf of the Medicaid recipient. This is the same individual that completes and signs the Medicaid application on behalf of a covered individual, agreeing to the rights and responsibilities associated with Medicaid coverage.

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

Risk – The chance or possibility of loss. The member is at risk only for pharmacy copayments as allowed in the Medicaid State Plan and the cost of non-covered services. The MCO, with its income fixed, is at risk for whatever volume of care is entailed, however costly it turns out to be. Risk is also defined in insurance terms as the possibility of loss associated with a given population.

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

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

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

Rural Area – Refers to any parish in the state that meets the Office of Management and Budget definition of rural. (See Appendix LL for map of **Louisiana Rural Parishes**)

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

Rural Hospital – hospital licensed by DHH which meets the definition in R.S. 40:1300.143.

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

Scope of Services – See “Covered Services.”

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

Secondary Care – Health care services provided by medical specialists who generally do not have first contact with patients, but instead are referred to them by primary care providers.

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

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

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

Service Area – The designated area in which the MCO is authorized to furnish core benefits and services to enrollees. The service area is the entire state of Louisiana.

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

Shall – Denotes a mandatory requirement.

Should – Denotes a preference but not a mandatory requirement.

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

Significant Traditional Provider (STP) – Those Medicaid enrolled providers that provided the top eighty percent (80%) of Medicaid services for the MCO-eligible population in the base year of 2013.

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

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

Span of Control – Information systems and telecommunications capabilities that the MCO itself operates or for which it is otherwise legally responsible according to the terms and conditions with DHH. The span of control also includes systems and telecommunications capabilities outsourced by the MCO.

Special Health Care Needs Population – An individual of any age with a mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care requirements.

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

Specialized Behavioral Health Services (BHS) – Mental health services and substance abuse services that include, but are not limited to, services specifically defined in the state plan and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider.

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

Start-Up Date – The date MCO providers begin providing medical care to their Medicaid members. Also referred to as operations start date and "go-live :date.

State – The state of Louisiana.

State Plan – Refers to the Louisiana Medicaid State Plan.

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

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

Subsidiary – Means an affiliate controlled by such person or entity directly or indirectly through one (1) or more intermediaries.

Subspecialist Services – **See Specialty Services**

Supplemental Security Income (SSI) – A federal program which provides a cash benefit to people who are aged, blind or disabled and who have little or no income or assets Louisiana is a "Section 1634" state and anyone determined eligibility for SSI is automatically eligible for Medicaid.

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

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

System Unavailability – Measured within the MCO's information system span of control. A system is considered not available when a system user does not get the complete, correct full-

screen response to an input command within three (3) minutes after depressing the "enter" or other function key.

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

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

Tenancy Supports – Supports provided under CPST to that subset of recipients accepted for participation in Louisiana's Permanent Supportive Housing program. Tenancy and pre-tenancy supports are designed to help members access and maintain successful tenancy in the community-integrated, affordable housing provided through Louisiana's PSH program. Tenancy and pre-tenancy supports consist of activities such as helping members complete apartment applications, seek reasonable accommodation, negotiate and enter into leases, understand the role of tenant, understand tenant rights, develop budgets, make timely rent payments, comply with terms of lease, adjust to new home and neighborhood (including how to get to and access essential services), apply for income benefits such as SSI, comply with medication and other treatment regimes, and develop/implement crisis plans to avoid eviction.

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

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

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

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

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

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

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

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

Transition Phase – Includes all activities the MCO is required to perform between the Contract effective date and the implementation date for the MCO.

Treatment Planning – is an administrative treatment planning activity provided under Medicaid requirements at 42 CFR §438.208(c) for entities for developing and facilitating implementation of individualized Plans Of Care. Treatment planning is provided to address the unique needs of

clients living in the community and does not duplicate any other Medicaid State Plan service or services otherwise available to the recipient at no cost.

Treatment Planner – The function of the Treatment Planner is to produce a community-based, individualized treatment plan. This includes working with the individual and/or family to identify who should be involved in the treatment planning process. The Treatment Planner guides the treatment plan development process. The Treatment Planner also is responsible for subsequent treatment plan review and revision as needed, under established guidelines, to review the treatment plan and more frequently when changes in the member's circumstances warrant changes in the treatment plan. The Treatment Planner will emphasize building collaboration and ongoing coordination among the family, caretakers, service providers, and other formal and informal community resources identified by the family and promote flexibility to ensure that appropriate and effective service delivery to the child or adult and family/caregivers.

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

Turnover Plan – means the written plan developed by the MCO, approved by DHH, to be employed during the turnover phase.

Universal Rate – The PMPM rate initially paid to MCOs prior to the first risk adjustment, calculated using fee-for-service (FFS) data for the entire MCO population.

Urban Area – Refers to a geographic area that meets the definition of urban area at §412.62(f)(1)(ii) which is a Metropolitan Statistical Area (MSA) as defined by the Executive Office of Management and Budget; A list of Louisiana parishes in Metropolitan Statistical Areas can be found at http://www.doa.louisiana.gov/census/metroareas.htm

Urgent Care – Medical care provided for a condition that without timely treatment, could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily function, or cause the development of a chronic illness or need for a more complex treatment. Examples of conditions that require urgent care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, and suspected fracture. Urgent care requires timely face-to-face medical attention within 24 hours of member notification of the existence of an urgent condition.

Utilization – The rate patterns of service usage or types of service occurring within a specified time.

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

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

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

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

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

Waiting Time(s) – Time spent both in the lobby and in the examination room prior to being seen by a provider.

Waiver – Medicaid Section 1915(c) Home and Community Based Services (HCBS) programs which in Louisiana are New Opportunities Waiver (NOW), Children's Choice, Adult Day Health Care (ADHC), Elderly Disabled and Adult (EDA), Supports Waiver, Residential Options Waiver (ROW), and any other 1915(c) waiver that may be implemented. Participants in waivers are excluded from enrolling in an MCO.

Week – The entire seven-day week, Monday through Sunday.

Will – Denotes a mandatory requirement.

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

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

ACRONYMS

ADA – Americans with Disabilities Act

AFDC – Aid to Families with Dependent Children

APRN - Advanced Practice Registered Nurse

ASAM – American Society of Addiction Medicine

BHS – Behavioral Health Services

BHSF – Bureau of Health Services Financing

CAH – Critical Access Hospital

CAHPS – The Consumer Assessment of Health Providers and Systems

CANS – Child and Adolescent Needs and Strengths

CAP – Corrective Action Plan

CCMP – Chronic Care Management Program

CDC – Centers for Disease Control and Prevention

CFR – Code of Federal Regulations

CHIP – Children's Health Insurance Program

CM - Care Manager

CMS – Centers for Medicare and Medicaid Services

CNM – Certified Nurse Midwife

COB – Coordination of Benefits

CPT – Current Procedural Terminology

CSoC – Coordinated System of Care

DCFS – Department of Children and Family Services

DHH – Department of Health and Hospitals

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

DM – Disease Management

DME – Durable Medical Equipment

DMEPOS – Durable Medical Equipment, Prosthetics Orthotics and certain Supplies

DOI – Louisiana Department of Insurance

EB – Enrollment Broker

EBP – Evidenced Based Practices

EHR – Electronic Health Records

ELE – Express Lane Eligibility

EOB – Explanation of Benefits

EPSDT - Early and Periodic Screening, Diagnosis and Treatment

EQR – External Quality Review

EQRO - External Quality Review Organization

FDA – Food and Drug Administration

FFP – Federal Financial Participation

FFS –- Fee for Service

FI – Fiscal Intermediary

FQHC – Federally Qualified Health Center

FSO – Family Support Organization

FTE – Full-Time Equivalent

FY – Fiscal Year

HCBS – Home and Community Based Services Waiver

HCFA – Health Care Financing Administration

HEDIS – Healthcare Effectiveness Data and Information Set

HHS –United States Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act

HITECH – Health Information Technology for Economic and Clinical Health Act

HMO – Health Management Organization

HSIC - Human Services Interagency Council

IBNR – Incurred But Not Reported

IDEA – Individuals with Disabilities Education Act

IEP – Individualized Education Plan

IPAT – Integrated Practice Assessment Tool

IS – Information Systems

LAC – Licensed Addiction Counselor

LaCHIP – Louisiana Children's Health Insurance Program

LDOE – Louisiana Department of Education

LaHIPP – Louisiana Health Insurance Premium Payment Program

LGE – Local Governing Entity

LIFC – Low Income Families and Children

LMHP – Licensed Mental Health Professional

LOCUS – Level of Care Utilization System

MCO – Managed Care Organization

MH/SA – Mental Health/Substance Abuse

MHBG – Mental Health Block Grant

MHR – Mental Health Rehabilitation

MMIS – Medicaid Management Information System

MLR – Medical Loss Ratio

MVA – Medical Vendor Administration

NAIC – National Association of Insurance Commissioners

NCQA –National Committee for Quality Assurance

NEMT – Non-Emergency Medical Transportation

NOMS – National Outcome Measures

NP – Nurse Practitioner

NPI – National Provider Identifier

OJJ – Office of Juvenile Justice

OON – Out of Network Provider

P&T – Pharmaceutical and Therapeutics

PA – Physician's Assistant

PASRR – Pre-Admission Screening and Resident Review

PBM – Pharmacy Benefit Manager

PCCM – Primary Care Case Manager

PCP – Primary Care Provider

PCS – Personal Care Services

PDL – Preferred Drug List

PHI – Personal Health Information

PHR – Personal Health Record

PIP – Performance Improvement Projects

PMP - Prescription Monitoring Program

PMPM – Per Member, Per Month

PPC – Provider Preventable Condition

PPS – Prospective Payment System

PRTF - Psychiatric Residential Treatment Facilities

PSAO - Pharmacy Services Administrative Organization

PSH – Permanent Supportive Housing

QAPI – Quality Assessment and Performance Improvement Plan

QM – Quality Management

RFP – Request for Proposals

RHC – Rural Health Clinic

RN – Registered Nurse

SABG – Substance Abuse Block Grant

SBHC – School Based Health Center

SFTP – Secure File Transfer Protocol

SHCN – Special Health Care Needs

SMI – Serious Mental Illness

SSA – Social Security Act

SSI – Supplemental Security Income

STP – Significant Traditional Provider

TANF –Temporary Assistance for Needy Families

TEDS – Treatment Episode Data Sets

TPL – Third Party Liability

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

UM – Utilization Management

UR – Utilization Review

WAA – Wraparound Agency

WIC – Women, Infants and Children Program

LIST OF APPENDICES TO RFP

This RFP should be considered to be comprised of all appendices herein. The list inclides mandatory requirements for proposals to be considered complete as described in Appendix KK.

Appendix A – Certification Statement

Appendix B – DHH Standard Contract Form (CF-1)

Appendix C – HIPAA Business Associate Agreement

Appendix D – Veterans Hudson Initiative

Appendix E – Reserved

Appendix F – Louisiana Standardized Credentialing Application Form

Appendix G – Rates with Actuarial Rate Certification Letter

Appendix H – MLR (Medical Loss Ratio) Calculation Methodology

Appendix I – Reserved

Appendix J – MCO Performance Measures

Appendix K – WIC Referral Form

Appendix L – Hysterectomy Consent Form

Appendix M – Sterilization Consent Form

Appendix N – Abortion Consent Form

Appendix O – MCO Subcontract Requirements

Appendix P – MCO Data Use Agreement

Appendix Q – Requirements for MCO Physician Incentive Plans

Appendix R – Provider's Bill of Rights

Appendix S – Request for Newborn ID Manual

Appendix T – MCO Request for Member Disenrollment

Appendix U – Guidelines for Member Disenrollment

Appendix W – Enrollment Broker Responsibilities

Appendix X – DHH Event Submission Form

Appendix Y – Reserved

Appendix Z – DHH Marketing Complaint Form

Appendix AA – Member's and Potential Member's Bill of Rights

Appendix BB – Marketing Plan Monthly Report

Appendix CC – Grievance and Appeal and Fair Hearing Log Report

Appendix DD – Performance Improvement Projects

Appendix EE – Reserved

Appendix FF – MCO Provider and Subcontractor Listing

Appendix GG – Reserved

Appendix HH – EPSDT Reporting

Appendix II – Model Attestation Letter for Reports

Appendix JJ – Transition Period Requirements

Appendix KK – MCO Proposal Submission and Evaluation Documents

Appendix LL – Louisiana Rural Parishes Map

Appendix MM – Attestation of Provider Network Submission

Appendix NN – Person First Policy

Appendix OO – Emergency Management Plan Template

Appendix PP – Provider Incentive Payments Template

Appendix QQ – Reference Questionnaire

Appendix RR – MCO-OPH MOU

Appendix SS – Provider Network - Appointment Availability Standards

Appendix TT – Network Providers by Specialty Type

Appendix UU – Provider Network - Geographic and Capacity Standards

Appendix VV – Medicaid Ownership and Disclosure Form

Appendix WW – HEDIS Reporting

LIST OF MCO COMPANION GUIDES

1. **Financial Reporting Companion Guide**
2. **MCO Systems Companion Guide**
3. **State Fair Hearing Companion Guide**
4. **MCO Quality Companion Guide**
5. **MCO Encounter Data Companion Guide**
6. **Behavioral Health Companion Guide**
7. **Reporting Companion Guide**

Subcontract Requirements Checklist for MCOs

Plan Name:

Subcontractor Name:

Summary of services to be provided:

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	DHH Feedback
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between DHH and the MCO and the department issued guides and either physically incorporating these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.		
2	Include a signature page that contains a MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for renewals as well).		
3	Specify the effective dates of the subcontract agreement.		
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.		
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.		
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.		
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and DHH for any of the reasons described in the contract, the MCO shall immediately make available to DHH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to DHH.		

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	DHH Feedback
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.		
9	Require that if any requirement in the subcontract is determined by DHH to conflict with the contract between DHH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.		
10	Identify the population covered by the subcontract.		
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to members through the last day that the subcontract is in effect.		
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.		
13	Specify the amount, duration and scope of benefits and services that are provided by the subcontractor.		
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.		
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 CFR §§ 493.1 and 493.3, and any other federal requirements.		
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO members pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between DHH and the MCO). MCO members and their representatives shall be given access to and can request copies of the members' medical records, to the extent and in the manner provided by LRS 40:1299.96 and 45 CFR 164.524 as amended and subject to reasonable charges.		
17	Include record retention requirements as specified in the contract between DHH and the MCO.		

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18	Shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The MCO 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.		
19	Require the subcontractor to submit to the MCO a disclosure of ownership in accordance with RFP Section 15.1.10. **The completed disclosure of ownership must be submitted with the checklist.**		
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or DHH or its designee.		
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by DHH or its designee.		
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by DHH.		
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontractual and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by DHH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.		
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by DHH.		

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	DHH Feedback
25	Require safeguarding of information about MCO members according to applicable state and federal laws and regulations and as described in contract between DHH and the MCO.		
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.		
27	Provide that the subcontractor comply with DHH's claims processing requirements as outlined in the RFP.		
28	Provide that the subcontractor adhere to DHH's timely filing guidelines as outlined in the RFP.		
29	Provide that, if a subcontractor discovers an error or a conflict with a previously adjudicated encounter claim, MCO shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by DHH or if circumstances exist that prevent contractor from meeting this time frame a specified date shall be approved by DHH.		
30	Provide that the subcontractor, if performing a key internal control, submit to an independent SSAE 16 SOC type 1 and/or type II audit of its internal controls and other financial and performance audits from outside companies to assure both the financial viability of the (outsourced) program and the operational viability, including the policies and procedures placed into operation. The audit firm will conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. When required by DHH, the subcontractor must provide a quality control plan, such as third party Quality Assurance (QA), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits.		
31	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from DHH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.		

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	DHH Feedback
32	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold DHH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between DHH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between DHH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by DHH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by DHH.		
33	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's members and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.		
34	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services.		
35	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.		
36	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.		
37	Include a conflict of interest clause as stated in the contract between DHH and the MCO.		
38	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between DHH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.		
39	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.		

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40	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) and its implementing regulation at 45 CFR Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.		
41	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.		
42	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.		
43	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor 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.		
44	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Bayou Health. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.		