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: 2000412922
Vendor: MCNA Insurance Company
Description: Contractor provides managed dental care services to Medicaid enrollees
Approved By: Pamela Rice
Approval Date: 10/08/2019

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

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

LDH - CF - 1
Revised: 2019-01-05

BHSF

CONTRACT BETWEEN STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH
Bureau of Health Services Financing

LAGOV:
LDH:
Agency # 305

AND

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

FOR

☐ Interagency ☐ Personal Services ☐ Professional Services ☒ Consulting Services ☐ Social Services

RFP NUMBER (If applicable):

1) Contractor (Registered Legal Name) MCNA Insurance Company, d/b/a MCNA Dental Plans	5) Federal Employer Tax ID# State LDR Account # 52245996900
2) Street Address 200 West Cypress Creek Road, Suite 500	6) Parish(es) Served Statewide ST
City: Fort Lauderdale State: FL Zip Code: 33309	7) License or Certification #
3) Telephone Number (800)494-6262	8) Contractor Status [!] Subrecipient: ☐ Yes ☒ No Corporation: ☒ Yes ☐ No For Profit: ☒ Yes ☐ No Publicly Traded: ☐ Yes ☒ No
4) Mailing Address (If different)	
City: State: Zip Code:	8a) CFDA#(Federal Grant #)

9) **Brief Description Of Services To Be Provided:** [!]

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

10) Effective Date 07-01-2019	11) Termination Date 06-30-2020

12) **Maximum Contract Amount** $179,341,913.00

13) **Estimated Amounts by Fiscal Year** SFY 20 - $179,341,913

14) **Terms of Payment** [!]

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

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

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

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

Attachment A: HIPAA Addendum
Attachment B: Statement of Work
Attachment C: Rate Certification

Exhibit 1: Board Resolution
Exhibit 2: Out of State Justification
Exhibit 3: Certificate of Authority
Exhibit 4: Disclosure of Ownership

Attachment Standard Provisions
Attachment Special Provisions
Attachment Statement of Work
Attachment Fee Schedule
Attachment Budget
Attachment
Exhibit Board Resolution
Exhibit Disclosure of Ownership
Exhibit Multi Year Letter
Exhibit Late Letter
Exhibit Out of State Justification
Exhibit Certificate of Authority
Exhibit Resume
Exhibit License
Exhibit

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During the performance of this contract, the Contractor hereby agrees to the following terms and conditions:

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

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

2. **Confidentiality:** Contractor shall abide by the laws and regulations concerning confidentially which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of the Department, confidentiality rules and facility access procedures.)

3. **Auditors:** The State Legislative Auditor, Office of the Governor, Division of Administration, and Department Auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this contract during the contract and for a five year period following final payment. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor, Louisiana Department of Health, and Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.

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

4. **Record Retention:** Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit or copy records at the contractor's site, without expense to the Department.

5. **Record Ownership:** All records, reports, documents and other material delivered or transmitted to Contractor by the Department shall remain the property of the Department, and shall be returned by Contractor to the Department, at Contractor's expense, at termination or expiration of this contract. All records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of the Department, and shall, upon request, be returned by Contractor to the Department, at Contractor's expense, at termination or expiration of this contract.

6. **Nonassignability:** Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from the Department under this contract may be assigned to a bank, trust company or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the Department and the Division of Administration, Office of State Procurement.

7. **Taxes:** Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this contract shall be Contractor's. The Contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds.

8. **Insurance:** Contractor shall obtain and maintain during the contract term all necessary insurance including automobile insurance, workers' compensation insurance, and general liability insurance. The required insurances shall protect the Contractor, the Louisiana Department of Health, and the State of Louisiana from all claims related to Contractor's performance of this contract. Certificates of Insurance shall be filed with the Department for approval. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days advance written notice to the Department. Commercial General Liability Insurance shall provide protection during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as claims for property damages, with combined single limits prescribed by the Department.

9. **Travel:** In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations. The contract contains a maximum compensation which shall be inclusive of all charges including fees and travel expenses.

10. **Political Activities:** No funds provided herein shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the Legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition or matter having the effect of law being considered by the Legislature or any local governing authority. Contracts with individuals shall be exempt from this provision.

11. **State Employment:** Should Contractor become an employee of the classified or unclassified service of the State of Louisiana during the effective period of the contract, Contractor must notify his/her appointing authority of any existing contract with State of Louisiana and notify the contracting office of any additional state employment. This is applicable only to contracts with individuals.

12. **Ownership of Proprietary Data:** All non-third party software and source code, records, reports, documents and other material delivered or transmitted to Contractor by State shall remain the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract. All non-third party software and source code, records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract.

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

    No subcontract shall relieve the Contractor of the responsibility for the performance of contractual obligations described herein.

14. **Conflict of Interest:** Contractor warrants that no person and no entity providing services pursuant to this contract on behalf of Contractor or any subcontractor is prohibited from providing such services by the provisions of R.S. 42:1113.

15. **Unauthorized Services:** No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by the Department. In the event the Department determines that certain costs which have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, the Department shall have the right to set off and withhold said amounts from any amount due the Contractor under this contract for costs that are allowable.

16. **Fiscal Funding:** This contract is subject to and conditioned upon the availability and appropriation of Federal and/or State funds, and no liability or obligation for payment will develop between the parties until the contract has been approved by required authorities of the Department; and, if contract exceeds $2,000, the Division of Administration, Office of State Procurement.

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

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

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

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

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

18. **Amendments:** Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of the Department; and, if the contract exceeds $2,000, by the Division of Administration, Office of State Procurement. Budget revisions approved by both parties in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.

19. **Non-Infringement:** Contractor will warrant all materials, products and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against LDH, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in LDH's name, but at Contractor's expense and shall indemnify and hold harmless LDH against any loss, expense or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or other allied health providers solely for medical services.

20. **Purchased Equipment:** Any equipment purchased under this contract remains the property of the Contractor for the period this contract and future continuing contracts for the provision of the same services. Contractor must submit vendor invoice with reimbursement request. For the purpose of this contract, equipment is defined as any tangible, durable property having a useful life of at least (1) year and acquisition cost of $1000.00 or more. The contractor has the responsibility to submit to the Contract Monitor an inventory list of LDH equipment items when acquired under the contract and any additions to the listing as they occur. Contractor will submit an updated, complete inventory list on a quarterly basis to the Contract Monitor. Contractor agrees that upon termination of contracted services, the equipment purchased under this contract reverts to the Department. Contractor agrees to deliver any such equipment to the Department within 30 days of termination of services.

21. **Indemnity:** Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, LDH, from all claims for damages, costs, expenses and attorney fees arising in contract or tort from this contract or from any acts or omissions of Contractor's agents, employees, officers or clients, including premises liability and including any claim based on any theory of strict liability. This provision does not apply to actions or omissions for which R.S. 40:1237.1 et seq. provides malpractice coverage to the Contractor, nor claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (R.S. 13:5108.1(E)). Further, it does not apply to premises liability when the services are being performed on premises owned and operated by LDH.

22. **Severability**: Any provision of this contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in State and Federal law, or applicable State or Federal regulations.

23. **Entire Agreement**: Contractor agrees that the current contract supersedes all previous contracts, negotiations, and all other communications between the parties with respect to the subject matter of the current contract.

24. **E-Verify**: Contractor acknowledges and agrees to comply with the provision of R.S. 38:2212.10 and federal law pertaining to E-Verify in the performance of services under this contract.

25. **Remedies for Default**: Any claim or controversy arising out of this contract shall be resolved by the provisions of R.S. 39:1672.2-1672.4.

26. **Governing Law**: This contract shall be governed by and interpreted in accordance with the laws of the State of Louisiana, including but not limited to R.S. 39:1551-1736; rules and regulations; executive orders; standard terms and conditions, and specifications listed in the RFP (if applicable); and this Contract.

27. **Contractor's Cooperation**: The Contractor has the duty to fully cooperate with the State and provide any and all requested information, documentation, etc. to the state when requested. This applies even if this Contract is terminated and/or a lawsuit is filed. Specifically, the Contractor shall not limit or impede the State's right to audit or shall not withhold State owned documents.

28. **Continuing Obligation**: Contractor has a continuing obligation to disclose any suspension or debarment by any government entity, including but not limited to the General Services Administration (GSA). Failure to disclose may constitute grounds for suspension and/or termination of the Contract and debarment from future contracts.

29. **Eligibility Status**: Contractor and each tier of Subcontractors, shall certify that it is not excluded, disqualified, disbarred, or suspended from contracting with or receiving federal funds or grants from the Federal Government. Contractor and each tier of Subcontractors shall certify that it is not on the List of Parties Excluded from Federal Procurement and Nonprocurement Programs promulgated in accordance with E.O.s 12549 and 12689, "Debarment and Suspension," as set forth at 24CFR Part 24, and "NonProcurement Debarment and Suspension" set forth at 2CFR Part 2424.

30. **Act 211 Taxes Clause**: In accordance with R.S. 39:1624(A)(10), the Louisiana Department of Revenue must determine that the prospective contractor is current in the filing of all applicable tax returns and reports and in payment of all taxes, interest, penalties, and fees owed to the state and collected by the Department of Revenue prior to the approval of this contract by the Office of State Procurement. The prospective contractor hereby attests to its current and/or prospective compliance, and agrees to provide its seven-digit LDR Account Number to LDH so that the prospective contractor's tax payment compliance status may be verified. The prospective contractor further acknowledges understanding that issuance of a tax clearance certificate by the Louisiana Department of Revenue is a necessary precondition to the approval and effectiveness of this contract by the Office of State Procurement. LDH reserves the right to withdraw its consent to this contract without penalty and proceed with alternate arrangements should the vendor fail to resolve any identified apparent outstanding tax compliance discrepancies with the Louisiana Department of Revenue within seven (7) business days of such notification.

31. **Termination for Cause:** The Department may terminate this Contract for cause based upon the failure of the Contractor to comply with the terms and/or conditions of the Contract; provided that the Department shall give the Contractor written notice specifying the Contractor's failure. If within thirty (30) days after receipt of such notice, the Contractor shall not have either corrected such failure or, in the case of failure which cannot be corrected in thirty (30) days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction, then the Department may, at its option, place the Contractor in default and the Contract shall terminate on the date specified in such notice. The Contractor may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of the Department to comply with the terms and conditions of this contract; provided that the Contractor shall give the Department written notice specifying the Department's failure and a reasonable opportunity for the state to cure the defect.

32. **Termination for Convenience**: The Department may terminate this Contract at any time by giving thirty (30) days written notice to the Contractor. The Contractor shall be entitled to payment for deliverables in progress, to the extent work has been performed satisfactorily.

33. **Prohibition of Discriminatory Boycotts of Israel:** In accordance with Louisiana R.S. 39:1602.1, for any contract for $100,000 or more and for any contractor with five or more employees, Contractor, or any Subcontractor, shall certify it is not engaging in a boycott of Israel, and shall, for the duration of this contract, refrain from a boycott of Israel. The State reserves the right to terminate this contract if the Contractor, or any Subcontractor, engages in a boycott of Israel during the term of the contract.

34. **Countersignature**: This contract may be executed in two or more counterparts, each of which shall be deemed an original, but all of which, taken together, shall constitute one and the same instrument.

35. **No Employment Relationship**: Nothing in this Agreement shall be construed to create an employment or agency relationship, partnership or joint venture between the employees, agents, or subcontractors of the Contractor and the State of Louisiana.

36. **Commissioner's Statements**: Statements, acts and omissions made by or on behalf of the Commissioner of Administration regarding the RFP or RFP process, this Contract, any Contractor and/or any subcontractor of the Contractor shall not be deemed a conflict of interest when the Commissioner is discharging his duties and responsibilities under law, including, but not limited, to the Commissioner of Administration's authority in procurement matters.

37. **Order of Precedence Clause**: In the event of any inconsistent or incompatible provisions in an agreement which resulted from an RFP, this signed agreement (excluding the RFP and Contractor's proposal) shall take precedence, followed by the provisions of the RFP, and then by the terms of the Contractor's proposal. *This Order of Precedence Clause applies only to contracts that resulted from an RFP.*

SIGNATURES TO FOLLOW ON THE NEXT PAGE

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

MCNA Insurance Company, d/b/a MCNA Dental Plans	STATE OF LOUISIANA LOUISIANA DEPARTMENT OF HEALTH
6/20/19	
SIGNATURE DATE	SIGNATURE DATE
Carlos Lacasa	
NAME	NAME
Senior Vice President and General Counsel	Secretary, Louisiana Department of Health or Designee
TITLE	TITLE
	Bureau of Health Services Financing
	6/26/19
SIGNATURE DATE	SIGNATURE DATE
	Jen Steele
NAME	NAME
	Medicaid Director
TITLE	TITLE

Rev. 06/2016

HIPAA Business Associate Addendum

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

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

I. SCOPE OF WORK

A. Project Overview

The Dental Benefit Program Manager (DBPM) is a risk-bearing, Prepaid Ambulatory Health Plan (PAHP) healthcare delivery system responsible for providing specified Medicaid dental benefits and services for eligible Louisiana Medicaid enrollees as described in this document.

In order to participate as a network for dental services, the DBPM must meet the following mandatory requirements:

1. meet the federal definition of a PAHP, as defined in 42 C.F.R. §438.2;
2. have a license or certificate of authority issued by the Louisiana Department of Insurance (DOI) to operate as a Medicaid risk bearing "prepaid entity" pursuant to LSA-R.S. 22:1016;
3. have a certificate from the Louisiana Secretary of State, pursuant to LSA-R.S. 12:24, to conduct business in the state, which is submitted to LDH at the time the DBPM signs the Contract with LDH;
4. meet solvency standards as specified in 42 C.F.R. §438.116 and Title 22 of the Louisiana Revised Statutes;
5. have a network capacity to enroll a minimum of 1,600,000 Medicaid members into the network;
6. is without an actual or perceived conflict of interest that would interfere or give the appearance of impropriety or of interfering with the contractual duties and obligations under this Contract or any other contract with LDH, and any and all applicable LDH written policies. Conflict of interest shall include, but is not limited to, the Contractor serving, as the Medicaid fiscal intermediary contractor for LDH;
7. have the ability to provide core dental benefits and services to all assigned members on the day the Dental Benefit Manager Program is implemented.

B. Deliverables

1. General Requirements

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

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

C. The DBPM 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 PAHPs are specified in 42 CFR Part 438 and will govern this Contract. LDH 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.

D. The Louisiana Department of Insurance (DOI) regulates the solvency of risk-bearing entities providing Louisiana Medicaid services; therefore, the DBPM must comply with all DOI applicable standards. Information pertaining to DOI can be found at DOI's website (www.ldi.louisiana.gov).

E. The DBPM shall submit documentation as specified by the state, but no less frequently than the following: 1) at the time it enters into a contract with the state; 2) on an annual basis; 3) at any time there has been a significant change (as defined by the state) in the DBPM's operations that would affect the adequacy of capacity and services, including changes in DBPM services, benefits, geographic service area, composition of or payments to its

provider network, or at the enrollment of a new population in the DBPM. [42 CFR §438.207(b) - (c)]

2. Programmatic Requirements

A. Mandatory Population

The DBPM will serve eligible Louisiana Medicaid enrollees in the following categories except those listed in the excluded population section below:

1. Group A - as specified in LAC 50:XV.6901, Medicaid beneficiaries who are under 21 years of age; and
2. Group B - as specified in LAC 50:XXV.303, Medicaid beneficiaries who are 21 years of age and older and whose Medicaid coverage includes the full range of Medicaid services.

B. Excluded Populations

1. Individuals residing in Intermediate Care Facilities for the Developmentally Disabled (ICF/DD); and
2. Individuals who are 21 years of age and older that are certified as Qualified Medicare Beneficiary Only.

C. Primary Dental Provider

1. The DBPM shall offer each enrollee a choice of primary dental providers (PDPs). After making a choice, each enrollee shall have a single or group PDP.
2. When making PDP assignments, the DBPM shall take into consideration the enrollee's last PDP (if the PDP is known and available in the DBPM's network), closest PDP to the enrollee's ZIP code location, keeping children/adolescents within the same family together, and age.
3. The DBPM shall permit enrollees to request to change PDPs at any time. If the enrollee request is not received by the DBPM’s established monthly cut-off date for system processing, the PDP change will be effective the first (1st) day of the next month.
4. The DPBM shall assign all enrollees who are reinstated after a temporary loss of eligibility to the PDP who was treating them prior to loss of eligibility, unless the enrollee specifically requests another PDP, the PDP no longer participates in the DBPM or is at capacity, or the enrollee has changed geographic areas.

D. Core Dental Benefits And Services

<u>General Provisions</u>

1. The DBPM shall provide members, at a minimum, with those core dental benefits and services specified in the Contract and as defined in the Louisiana Medicaid State Plan, administrative rules and Medicaid Policy and Procedure manuals. The DBPM shall possess the expertise and resources to ensure the delivery of quality healthcare services to DBPM members in accordance with Louisiana Medicaid program standards and the prevailing dental community standards.
2. The DBPM shall provide a mechanism to reduce inappropriate and duplicative use of healthcare services. Services shall be furnished in an amount, duration, and scope that is not less than the amount, duration, and scope for the same services furnished to those that are eligible under Fee For Service (FFS) Medicaid, as specified in 42 CFR §438.210(a)(1) and (2). Upward variances of amount, duration and scope of these services are allowed.

3. Although the DBPM shall provide the full range of required core dental benefits and services listed below, it may voluntarily choose to provide services over and above those specified when it is cost effective to do so. The DBPM may offer additional benefits that are outside the scope of core dental 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 DBPM may provide alternative services or deliver services in alternative settings in accordance with 42 CFR §438.3(e).
4. If new dental services are added to the Louisiana Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contract shall be amended and the Department will make every effort to give the DBPM sixty (60) days advance notice of the change. However, the DBPM shall add, delete, or change any service as may be deemed necessary by LDH within the timeframe required by LDH if mandated by federal or state legislation or court order.
5. The Louisiana Medicaid State Plan, Section 3 – Services: General Provisions, provides a general overview of Louisiana Medicaid services, which are identified as either federally mandated or state legislatively approved optional services.
6. The DBPM shall provide core dental benefits and services to Medicaid members based on their eligibility group:

Group A (Children Under Age 21)

This DBPM shall provide Group A the services listed in LAC 50:XV.6903 and as specified in Section 16.5 of the Dental Services Manual which include but are not limited to the following services:

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

- **Preventive Services** which include prophylaxis, topical fluoride treatments, sealants, fixed space maintainers and re-cementation of space maintainers;

- **Restorative Services** which include amalgam restorations, composite restorations, stainless steel and polycarbonate crowns, stainless steel crowns with resin window; pins, core build-ups, pre-fabricated posts and cores, resin-based composite restorations, appliance removal, and unspecified restorative procedures;

- **Endodontic Services** which include pulp capping, pulpotomy, endodontic therapy on primary and permanent teeth (including treatment plan, clinical procedures and follow-up care), apexification/recalcification, apicoectomy/periradicular services and unspecified endodontic procedures;

- **Periodontal Services** which include gingivectomy, periodontal scaling and root planning, full mouth debridement, and unspecified periodontal procedures;
- **Removable Prosthodontics** services which include complete dentures, partial dentures, denture repairs, denture relines and unspecified prosthodontics procedures;

- **Maxillofacial Prosthetics** service;

- **Fixed Prosthodontics** services which include fixed partial denture pontic, fixed partial denture retainer and other unspecified fixed partial denture services;

- **Oral and Maxillofacial Surgery** services which include non-surgical extractions, surgical extractions, coronal remnants extractions, other surgical procedures, alveoloplasty, surgical incision, temporomandibular joint (TMJ) procedure and other unspecified repair procedures;

- **Orthodontic Services** which include interceptive and comprehensive orthodontic treatments, minor treatment to control harmful habits and other orthodontic services; and **Adjunctive General Services** which include palliative (emergency) treatment, anesthesia, professional visits, miscellaneous services, and unspecified adjunctive procedures.

EPSDT Services

1. In accordance with 42 CFR §441.56(b)(1)(vi) and periodicity charts posted on Louisiana Medicaid's website at www.lamedicaid.com, the DBPM shall provide dental screening services furnished by direct referral to a dentist for children beginning at the eruption of the first tooth and no later than 12 months and within 90 days of the effective date of enrollment for all other enrollees.
2. In accordance with 42 CFR §441.56(c)(2), the Contractor shall provide dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

Group B (Adult Denture Program Age 21 and Above)

This Health Plan shall provide Group B the services listed in LAC 50:XXV.501 and as specified in Section 16.9 of the Dental Services Manual which include but is not limited to the following services:

- Comprehensive oral examination;
- Intraoral radiographs, complete series;
- Complete denture, maxillary;
- Complete denture, mandibular;
- Immediate denture, maxillary;
- Immediate denture, mandibular;
- Maxillary partial denture, resin base (including clasps);
- Mandibular partial denture, resin base (including clasps);
- Repair broken complete denture base;
- Replace missing or broken tooth, complete denture, per tooth;
- Repair resin denture base, partial denture;
- Repair or replace broken clasp, partial denture;
- Replace broken teeth, partial denture, per tooth;
- Add tooth to existing partial denture;
- Add clasp to existing partial denture;
- Reline complete maxillary denture (laboratory);
- Reline complete mandibular denture (laboratory);
- Reline maxillary partial denture (laboratory);
- Reline mandibular partial denture (laboratory); and
- Unspecified removable prosthodontic procedure.

3. The DBPM 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.

4. The DBPM 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.
5. The DBPM may place appropriate limits on a service (a) on the basis of certain criteria, such as medical necessity; or (b) for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.
6. The DBPM may exceed the service limits as specified in the Louisiana Medicaid State Plan to the extent that those service limits can be exceeded with authorization in FFS Medicaid. No dental service limitation can be more restrictive than those that currently exist under the Louisiana Medicaid State Plan.
7. The DBPM may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care.
8. The DBPM shall not portray core dental benefits or services as an expanded health benefit.

Emergency Dental Services

The DBPM shall make provisions for and advise all members, described in Group A, of the provisions governing emergency use and provide all services outlined in 42 CFR §438.114, including payment to out-of-network provides. Additional requirements for the DBPM to provide emergency dental services are as follows:

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

    a) Require prior authorization for emergency dental services and care.
    b) Indicate that emergencies are covered only if care is secured within a certain period of time.
    c) Use terms such as “life threatening” or “bona fide” to qualify the kind of emergency that is covered.
    d) Deny payment based on the member’s failure to notify the DBPM in advance or within a certain period of time after the care is given.

2. The DBPM shall not deny payment for emergency dental care.
3. The DBPM shall not deny payment for treatment obtained when a member had an emergency dental condition, including cases in which the absence of immediate dental attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of an emergency dental condition.
4. The DBPM shall not deny emergency dental services claims submitted by a non-contracting provider solely based on the period between the date of service and the date of clean claim submission unless that period exceeds 365 days.
5. If third party liability exists, payment of claims shall be determined in accordance with this contract.
6. The DBPM must review and approve or disapprove emergency service claims based on the definition of emergency dental services and care specified in the Glossary.

Prohibited Services

The DBPM is prohibited from providing:

1. Experimental/investigational drugs, procedures or equipment, unless approved by the secretary of LDH; or

2. Elective cosmetic surgery.

Expanded Services/Benefits

The DBPM shall provide LDH a description of the expanded services/benefits to be offered by the DBPM for approval. Additions or modifications to expanded services/benefits made during the contract period must be submitted to LDH, for approval.

1. As permitted under 42 CFR §438.3(e),the DBPM may offer expanded services and benefits to enrolled Medicaid DBPM members in addition to those core dental benefits and services specified in this contract.
2. These expanded services may include dental 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.
3. These services/benefits shall be specifically defined by the DBPM in regard to amount, duration and scope. LDH will not provide any additional reimbursement for these services/benefits. The DBPM may not seek reimbursement for these services from the enrollees.

3. Operations Requirements

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

B. DBPM Reimbursement

1. LDH shall make monthly capitated payments for each member enrolled into the DBPM in accordance with the capitation rates specified in Attachment D – Mercer Certification, Rate Development Methodology and Rates. The capitation rate will be developed in accordance with 42 CFR §438.6 and will include claims for retroactive coverage. The rates will be periodically reviewed and may be periodically adjusted.
2. DBPM agrees to accept payment in full and shall not seek additional payment from a member for any unpaid costs, including costs incurred during the retroactive period of eligibility.
3. LDH reserves the right to defer remittance of the PMPM payment for June until the first Medicaid Management Information System (MMIS) payment cycle in July to comply with state fiscal policies and procedures.
4. DBPM Payment Schedule
   a) The monthly capitated payment shall be based on Medicaid beneficiaries eligible for DBPM participation during the month and paid in the weekly payment cycle nearest the 15th calendar day of the month.
   b) The DBPM shall make payments to its providers as stipulated in the contract.
   c) The DBPM shall not assign its right to receive payment to any other entity.
   d) Payment for items or services provided under this contract shall 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.
   e) The DBPM shall agree to accept payments as specified in this section and have written policies and procedures for receiving and processing payments and adjustments. Any charges or expenses

imposed by financial institutions for transfers or related actions shall be borne by the DBPM.

f) Withhold of Capitation Rate

(1) A withhold of the aggregate capitation rate payment shall be applied to provide an incentive for DBPM compliance with the requirements of this contract.

(2) The withhold amount will be equivalent to two percent (2%) of the monthly capitation rate payment for all DBPM enrollees.

(3) If LDH has not identified any DBPM deficiencies, LDH will pay to the DBPM the withhold of the DBPM's payments withheld in the month subsequent to the withhold.

(4) If LDH has determined the DBPM is not in compliance with a requirement of this Contract in any given month, LDH may issue a written notice of non-compliance and LDH may retain the amount withheld for the month prior to LDH identifying the compliance deficiencies.

(5) Monthly retention of the withhold amount may continue for each subsequent month so long as the identified deficiencies have not been corrected. If the same or similar deficiency(s) continues beyond timeframes specified for correction as determined by LDH and documented in a written notice of action to the DBPM. LDH may permanently retain the amount withheld for the period of non-compliance consistent with the administrative actions, monetary penalties, sanctions and liquidated damages provisions of this Contract. The timeframe specified in the written notice of action shall be considered the cure period not less than 30 days unless the deficiency reasonably requires resolution in a shorter time frame after which amounts retained may be permanently withheld.

(6) Amounts withheld for failure to achieve established performance measurement goals, as defined in Section I.3.11.l.iii, may be permanently retained at LDH's discretion.

(7) No interest shall be due to the DBPM on any sums withheld or retained under this Section.

(8) The provisions of this Section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under this Contract.

5. Payment Adjustments

a) In the event that an erroneous payment is made to the DBPM, LDH shall reconcile the error by adjusting the DBPM's future monthly capitation payment.

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

c) The DBPM shall refund payments received from LDH for a deceased member effective the month of service after the month of death. LDH will recoup the payment as specified in the Systems Companion Guide.

d) The entire monthly capitation payment shall be paid during the month of birth and month of death. Payments shall not be pro-rated to adjust for partial month eligibility as this has been factored into the actuarial rate setting.

6. Rate Adjustments

a) LDH reserves the right to re-negotiate the PMPM rates:
- If the rate floor is removed;
- If a result of federal or state budget reductions or increases;
- If due to the inclusion or removal of a Medicaid covered dental service(s) not incorporated in the monthly capitation rates; or
- In order to comply with federal requirements.

b) The rates may also be adjusted due to the inclusion or removal of a Medicaid covered dental service(s) not incorporated in the monthly capitation rate; and/or based on legislative appropriations and budgetary constraints. Any adjusted rates must continue to be actuarially sound as determined by LDH's actuarial contractor and will require an amendment to the Contract that is mutually agreed upon by both parties. Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of the Department; and, if contract exceeds $2,000, approved by the Director of the Office of State Procurement, Division of Administration. Budget revisions approved by both parties in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.

7. Copayments

Any cost sharing imposed on Medicaid members must be in accordance with 42 CFR §§447.50 through 447.58 and cannot exceed cost sharing amounts in the Louisiana Medicaid State Plan. Louisiana currently has no cost sharing requirements for any of the DBPM core dental benefits and services. LDH reserves the right to amend cost sharing requirements.

8. Return of Funds

a) All amounts owed by the DBPM to LDH, as identified through routine or investigative reviews of records or audits conducted by LDH or other state or federal agency, shall be due no later than thirty (30) calendar days following notification to the DBPM by LDH unless otherwise authorized in writing by LDH. LDH, at its discretion, reserves the right to collect amounts due by withholding and applying all balances due to LDH to future payments. LDH reserves the right to collect interest on unpaid balances beginning thirty (30) calendar days from the date of initial notification. The rate of interest charged will be the same as that fixed by the Secretary of the United States Treasury as provided for in 45 CFR §30.13. This rate may be revised quarterly by the Secretary of the Treasury and is published by HHS in the Federal Register.

b) The DBPM shall reimburse all payments as a result of any federal disallowances or sanctions imposed on LDH as a result of the DBPM's failure to abide by the terms of the Contract. The DBPM shall be subject to any additional conditions or restrictions placed on LDH by the United States Department of Health and Human

Services (HHS) as a result of the disallowance. Instructions for returning of funds shall be provided by written notice.

9. Third Party Liability (TPL)

a) General TPL Information
   i. Pursuant to federal and state law, the Medicaid program by law is intended to be the payer of last resort. This means all other available Third Party Liability resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid, unless otherwise noted.
   ii. The DBPM shall take reasonable measures to determine Third Party Liability.
   iii. The DBPM shall coordinate benefits in accordance with 42 CFR §433.135, *et seq.,* and Louisiana Revised Statutes, Title 46, so that costs for services otherwise payable by the DBPM are cost avoided or recovered from a liable party. The two methods used are cost avoidance and post-payment recovery. The DBPM shall use these methods as described in federal and state law.
   iv. If the probable existence of Third Party Liability cannot be established the DBPM must adjudicate the claim. The DBPM must then utilize post-payment recovery which is described in further detail below.
   v. The term "state" shall be interpreted to mean "DBPM" for purposes of complying with the federal regulations referenced above. The DBPM may require subcontractors to be responsible for coordination of benefits for services provided pursuant to this contract.

b) Cost Avoidance
   i. Unless prohibited by applicable federal or state law or; regulations, The DBPM shall cost-avoid a claim if it establishes the probable existence of Third Party Liability at the time the claim is filed.
   ii. The DBPM shall bill the private insurance within sixty (60) days from date of discovery of liability.
   iii. The DBPM shall adjudicate claims for dental treatment associated with EPSDT in accordance with federal and state law.

c) Post-payment Recoveries

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

   i. The DBPM must have established procedures for recouping post-payments. The DBPM must void encounters for claims that are recouped in full. For recoupments that result in an adjusted claim value, the DBPM must submit replacement encounters.
   ii. The DBPM shall identify the existence of potential Third Party Liability to pay for core dental benefits and services in accordance with 42 CFR §433.138.
   iii. The DBPM must report the existence of Third Party Liability in a weekly file to the department fiscal intermediary in the specified format.
   iv. The DBPM 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 or less than $500.

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

vi. Prior to accepting a Third Party Liability settlement on claims equal to or greater than $25,000, the DBPM shall obtain approval from LDH. The DBPM may retain up to 100% of its Third Party Liability collections if all of the following conditions exist:

- Total collections received do not exceed the total amount of the DBPM financial liability for the member;
- There are no payments made by LDH related to FFS, reinsurance or administrative costs (*i.e.,* lien filing, etc.); and
- Such recovery is not prohibited by state or federal law.

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

d) TPL Reporting Requirements

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

ii. The DBPM shall be required to include the collections and claims information in the encounter data submitted to LDH, including any retrospective findings via encounter adjustments.

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

iv. Upon the request of LDH, the DBPM shall demonstrate that reasonable effort has been made to seek, collect and/or report Third Party Liability and recoveries. LDH shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices.

v. The DBPM must 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.

e) LDH Right to Conduct Identification and Pursuit of TPL

i. When the DBPM fails to collect payment from the Third Party Liability within three hundred sixty-five (365) days from date of service, LDH may invoke its right to pursue recovery.

ii. If LDH determines the DBPM is not actively engaged in cost avoidance the DBPM will be responsible for all administrative costs associated with this LDH's collection activities.

f) Coordination of Benefits

i. Other Coverage Information

ii. The DBPM shall maintain other coverage information for each member. The DBPM shall verify the other coverage information provided by LDH and develop a system to include additional other coverage information when it becomes available. The DBPM shall provide a periodic file of updates to other coverage back to the state.

iii. Cost Avoidance
The DBPM shall attempt to avoid payment in all cases where there is other insurance (Medicaid is payer of last resort).

iv. Post-Payment Recoupment
The DBPM shall initiate a post payment recovery process when it is determined after the fact that the member had other coverage at the time of service.

v. Reporting and Tracking
The DBPM'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.

10. Provider Network Requirements

a) General Provider Network Requirements

i. The DBPM must maintain a network of qualified dental providers in sufficient number, mix and geographic distribution to provide adequate access to all services covered under the contract for all enrollees in the service area, including those with limited English proficiency or physical or mental disabilities. The DBPM is expected to design a network that provides a geographically convenient flow of patients among network providers. The provider network shall be designed to reflect the needs and service requirements of the DBPM's member population. The DBPM shall design its dental provider network to maximize the availability of primary dental services and specialty dental services.

ii. The DBPM must provide a comprehensive network to ensure its membership has access at least equal to, or better than, community norms. Services shall be accessible to DBPM members in terms of timeliness, amount, duration and scope equal to services provided by fee for service (FFS) Medicaid at the time the DBPM is implemented [42 CFR §438.210(a)(2)]. If the network is unable to provide necessary services required under contract, the DBPM shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted. The DBPM shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR §438.206(b)(4) and (5)].

iii. All providers shall be in compliance with 42 CFR §438.206(c)(3) and Americans with Disabilities Act (ADA) requirements and provide physical access reasonable accommodations and accessible equipment for Medicaid members with disabilities.

iv. Request from Medicaid Providers, including significant traditional providers (STP) to participants in DBPM services are received, the DBPM should make a good faith effort to enter into a contract with such providers. The DBPM shall document

efforts made and maintain records for all successful and non-successful agreements.

v. The DBPM shall not discriminate with respect to participation in the Dental Benefit Program, reimbursement or indemnification against any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the provider's type of licensure or certification [42 CFR §438.12(a)(1) and (2)]. In addition, the DBPM must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR §438.214(c)].

vi. The provisions of this contract do not prohibit the DBPM from limiting provider participation to the extent necessary to meet the needs of the DBPM's members. This provision also does not interfere with measures established by the DBPM to control costs and quality consistent with its responsibilities under this contract nor does it preclude the DBPM from using reimbursement amounts that are less or greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR §438.12(b)(1)].

vii. The DBPM may decline requests from providers to participate in the DBPM network. Pursuant to [42 CFR §438.12(a)(1)], the DBPM shall give the Provider in written notice for reasons of its decision to decline the request. Response shall be within fourteen (14) calendar days from when the decision was made.

viii. The DBPM may terminate a contract with a provider for cause. In the event of termination of a provider agreement for cause, the DBPM shall provide immediate electronic notice to the provider, followed by a certified letter mailed within one (1) business day. The DBPM shall notify LDH of the termination as soon as the written notification of termination is sent to the provider, but no later than seven (7) calendar days after notification is given to the provider.

ix. The DBPM shall give written notice to DBPM members whose primary dental care provider's contract has been terminated. Notice shall be sent within fifteen (15) calendar days after receipt or issuance of the termination notice, as specified in 42 CFR §438.10(f)(1). This notice shall include a list of recommended network providers available to the member in their surrounding area.

x. The DBPM shall also meet the following requirements:
- Ensure the provision of all core dental benefits and services specified in the Contract. Accessibility of benefits/services, including geographic access, appointments, and wait times shall be in accordance with the requirements in this contract. These minimum requirements do not release the DBPM from ensuring that all necessary covered dental benefits and services required by its members are provided pursuant to this contract.
- Provide core dental services directly or enter into written agreements with providers or organizations that shall provide core dental services to the members in exchange for payment by the DBPM for services rendered.

- Not execute contracts with individuals or groups of providers who have been excluded from participation in Federal healthcare programs under either section 1128 or section 1128A of the Social Security Act [see 42 CFR §438.214(d)] or state funded healthcare programs. The list of providers excluded from federally funded healthcare programs can be found at http://exclusions.oig.hhs.gov/search.aspx and the Systems for Award Management at https://www.sam.gov and Health Integrity and Protection Data Bank at http://www.npdb-hipdb.hrsa.gov/index.jsp.
- Not prohibit, or otherwise restrict, a healthcare professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:
  - Member's health status, medical or behavioral healthcare, or treatment options, including any alternative treatment that may be self-administered;
  - Information the member needs in order to decide among all relevant treatment options;
  - The risk, benefits, and consequences of treatment and non-treatment; or
  - The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.
- Monitor provider compliance with applicable access requirements, including but not limited to, appointment and wait times, and take corrective action for failure to comply. The DBPM shall conduct appointment availability surveys annually. The surveys shall be submitted within 30 days after the conclusion of each contract year. The survey results must be kept on file and be readily available for review by LDH upon request. The DBPM may be subject to sanctions for noncompliance of providers with applicable appointment and wait time requirements set forth in this contract.
- If a member requests a provider who is located beyond access standards, and the DBPM has an appropriate provider within the DBPM who accepts new patients, it shall not be considered a violation of the access requirements for the DBPM to grant the member's request.
- The DBPM 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 interpreters in accordance with 42 CFR §438.206.
- The DBPM shall at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted providers. Failure to do so may result in monetary penalties up to $5,000 per day against the DBPM; whether the data is clean, current or accurate shall be at the discretion of LDH.

b) General Provider Network Requirements

The DBPM shall ensure access to dental services (distance traveled, waiting time, length of time to obtain an appointment, after-hours care) in accordance with the provision of services under this contract. LDH will monitor the DBPM's service accessibility and may require that the DBPM obtain services from out-of-network providers as necessary for the provision of core dental benefits and services. The DBPM shall provide

available, accessible, and adequate numbers of service locations, service sites, and dental professionals for the provision of core dental benefits and services, and shall take corrective action if there is failure to comply by any provider. At a minimum, this shall include:

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

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

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

c) Waiting Times and Timely Access

i. The DBPM shall ensure that its network providers have an appointment system for core dental benefits and services and/or expanded services which are in accordance with prevailing dental community standards as specified below.
ii. Formal policies and procedures establishing appointment standards must be approved by LDH. Revised versions of these policies and procedures should be submitted to LDH for record keeping purposes as they become relevant. If changes to policies and procedures are expected to have a significant impact on the provider network or member services, LDH staff must be notified in writing 30 days prior to implementation. Methods for educating both the providers and the members about appointment standards shall be addressed in these policies and procedures. The DBPM shall disseminate these appointment standard policies and procedures to its in-network providers and to its members. The DBPM shall monitor compliance with appointment standards and shall have a corrective action plan when appointment standards are not met.
iii. Urgent Care must be provided within twenty-four (24) hours of a request for services that do not require a request for authorization and within forty-eight (48) hours for a request for services that do require prior authorization. Urgent care may be provided directly by the primary care dentist or directed by the DBPM through other arrangements.
iv. Primary Dental Care – within thirty (30) days of request;
v. The DBPM shall establish processes to monitor and reduce the appointment "no-show" rate for primary care dentists. As best practices are identified, LDH may require implementation by the DBPM. This information shall be provided to LDH.
vi. The DBPM shall have written policies and procedures about educating its provider network about appointment time

requirements and provide these to LDH for approval. The DBPM must develop a corrective action plan when appointment standards are not met; if appropriate, the corrective action plan should be developed in conjunction with the provider [42 CFR §438.206(c)(1)(iv), (v) and (vi)]. Appointment standards shall be included in the Provider Manual. The DBPM is encouraged to include the standards in the provider subcontracts.

d) Assurance of Adequate Primary Care Dentist Access and Capacity

i. The primary care dentist may practice in a solo or group practice or may practice in a clinic (*i.e.,* a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or outpatient clinic). The DBPM shall provide at least one (1) full time equivalent (FTE) primary care dentist per five thousand (5,000) DBPM members. LDH defines a full time primary care dentist as a provider that provides dental care services for a minimum of thirty-two (32) hours per week of practice time..
ii. The DBPM shall provide access to dentists that offer extended office hours (minimum of 2 hours) at least one day per week (before 8:00 am and after 4:30 pm) and on Saturdays, within sixty (60) miles of a member's residence for urgent care.
iii. Network providers must offer office hours at least equal to those offered by fee for service (FFS) Medicaid
iv. The DBPM shall provide on or before the first of each month the primary care dentist with a report (electronic or hard copy) of all members linked to their practice.

e) Access to Specialty Providers

i. The DBPM shall ensure the availability of access to specialty providers for all Group A members. The DBPM shall ensure that access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.
ii. The DBPM shall establish and maintain a provider network of dentist specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the dental needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum:
    - The DBPM has signed a contract with providers of the specialty types listed below who accept new members and are available on at least a referral basis; and
    - The DBPM is in compliance with access and availability requirements.

iii. The DBPM shall ensure, at a minimum, the availability of the following providers, as appropriate for members under the age of 21:
    - Endodontists
    - Maxillofacial Surgeons
    - Oral Surgeons
    - Orthodontists
    - Pedodontists
    - Periodontists
    - Prosthodontists
    - Special Needs Pedodontists

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

v. The DBPM shall meet standards for timely access to all specialists. In accordance with 42 CFR §438.208(c)(4) for members determined to need a course of treatment or regular care monitoring, the DBPM must have a mechanism in place to allow members to directly access a specialist as appropriate for the member's condition and identified needs.

f) FQHC/RHC Clinic Services

i. The DBPM must offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) and include them in its provider network.

ii. If the DBPM does not enter into a contract with the FQHCs and/or RHCs within the geographic services area and within the time and distance travel standards of the primary dental care provider, the DBPM is not required to reimburse for out-of-network services. Exception is given when it is determined that the services provided were considered emergency services and in compliance with 42 CFR §438.114.

iii. The DBPM shall not enter into alternative reimbursement arrangements with FQHCs or RHCs without prior approval from LDH.

g) Significant Traditional Providers

The DBPM should make a good faith effort to include in its network, primary care dentists and specialists who are significant traditional providers (STPs) provided that the STP agrees to participate as an in-network provider and abide by the provisions of the provider contract and meets the credentialing requirements. The list of STPs will be available on the LDH web site.

h) Provider Network Development Management Plan

i. The DBPM shall maintain a provider Network Development and Management Plan which ensures that the provision of core dental benefits and services will occur [42 CFR §438.207(b)]. The Network Development and Management Plan shall be submitted to LDH for approval when significant changes occur and annually thereafter within thirty (30) days of the start of each contract year. The Network Development and Management Plan shall include the DBPM'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. The DBPM shall consider the following (42 CFR §438.206):

- Anticipated maximum number of Medicaid members;
- Expected utilization of services, taking into consideration the characteristics and healthcare needs of the members in the DBPM;
- The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core dental benefits and services;
- The numbers of DBPM providers who are not accepting new DBPM members; and

- 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.

ii. The Network Provider Development and Management Plan shall demonstrate the ability to provide access to Services and Benefits as defined in this contract, access standards in 42 CFR §438.206 and shall include:

- Assurance of Adequate Capacity and Services
- Access to Primary Care Dentists
- Access to Specialists
- Timely Access
- Service Area
- Second Opinion
- Out-of-Network Providers

iii. The Network Provider Development and Management Plan shall identify gaps in the DBPM's provider network and describe the process by which DBPM shall ensure that all covered services are delivered to DBPM members. Planned interventions to be taken to resolve such gaps shall also be included.

iv. The DBPM 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 DBPM shall provide updated GEO coding to LDH quarterly, or upon material change (as defined in the Section below) or upon request.

v. The DBPM shall develop and implement Network Development and Management policies and procedure that comply with 42 CFR §438.214(a) and (b).

vi. The DBPM shall communicate and negotiate with the network regarding contractual and/or program changes and requirements.

vii. The DBPM shall monitor network compliance with policies and rules of LDH and the DBPM, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes.

viii. The DBPM shall evaluate the quality of services delivered by the network;

ix. The DBPM shall provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area.

x. The DBPM shall 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, or with physical or mental disabilities.

xi. The DBPM shall process expedited and temporary credentials. Recruit, select, credential, re-credential and contract with providers in a manner that incorporates quality management, utilization, office audits and provider profiling.

xii. The DBPM shall provide training for its providers and maintain records of such training.

xiii. The DBPM shall track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate.

xiv. The DBPM shall ensure that provider complaints are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 calendar days of receipt (this does not include inquiries from LDH). If not resolved in 30 days the DBPM must document why the issue goes unresolved; however, the issue must be resolved within 90 calendar days.

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

i) Material Change to Provider Network

i. The DBPM shall provide written notice to LDH, within seven (7) business days, of any network provider contract termination that materially impacts the DBPM's provider network, whether terminated by the DBPM or the provider, and such notice shall include the reason(s) for the proposed action. A material change is defined as one which affects, or can reasonably be foreseen to affect, the DBPM's ability to meet the performance and network standards as described in the Contract, including but not limited to the following:

- Any change that would cause more than five percent (5%) of members to change the location where services are received or rendered.
- A decrease in the total of individual primary care dentists by more than five percent (5%);
- A loss of any participating specialist which may impair or deny the members' adequate access to providers; or
- Other adverse changes to the composition of which impair or deny the members' adequate access to providers.

ii. The DBPM 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.

iii. When the DBPM has advance knowledge that a material change will occur, the DBPM 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.

iv. 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.

v. LDH will respond within thirty (30) calendar days to the material change request and the notice received by DBPM. If LDH fails to respond within such time, the request and notice will be considered approved. Changes and alternative measures must be within the contractually agreed requirements. The DBPM shall within thirty (30) calendar days give advance written notice of provider network material changes to affected members. The DBPM shall notify LDH of emergency situation and submit request to approve material changes. LDH will act to expedite the approval process .

vi. The DBPM shall notify LDH within seven (7) calendar days 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 DBPM, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR 438.207(c)]. The notification shall include:
- Information about how the provider network change will affect the delivery of covered services, and
- The DBPM's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services

j) Coordination with Other Service Providers

The DBPM shall implement procedures for network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members to ensure that each enrollee has an ongoing source of care appropriate to their needs. Such other service providers may include: Medicaid Managed Care Organizations; Magellan; Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; FQHCs and RHCs; dental schools; dental hygiene programs; and parish school systems. Such cooperation may involve sharing of information (with the consent of the member). The DBPM shall formally designate a person or entity as primarily responsible for coordinating services accessed by the members. The DBPM shall provide the member information on how to contact their designated person or entity.

k) Subcontract Requirements

i. The DBPM shall provide or ensure the provision of all core dental benefits and services specified in the contract. The DBPM may provide these services directly or may enter into subcontracts with providers who will provide services to the members in exchange for payment by the DBPM for services rendered. Provider contracts are required with all providers of services unless otherwise approved by LDH. Any plan to delegate responsibilities of the DBPM to a subcontractor that meets the definition of "Major Subcontract" in the Glossary shall be submitted to LDH for approval.

ii. The DBPM shall have written policies and procedures for selection and retention of providers in accordance with 42 CFR §438.214.

iii. The subcontractor shall follow the State's credentialing and re-credentialing policy.

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

v. As required by 42 CFR §438.230, the DBPM 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:

- All provider subcontracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract;
- LDH shall have the right to review and approve or disapprove any and all major subcontracts entered into for the provision of any services under this contract;
- The DBPM must evaluate the prospective subcontractor's ability to perform the activities to be delegated;
- The DBPM must have a written agreement between the DBPM and the subcontractor that specifies the activities and reporting responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;
- The DBPM shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards; and
- The DBPM shall identify deficiencies or areas for improvement, and take corrective action.

vi. The DBPM shall submit all major subcontracts, excluding provider subcontracts, for the provision of any services under this contract to LDH for prior review and approval. LDH 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 contract.

vii. The DBPM shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§ 1128 (42 U.S.C. 1320a-7) or 1156 (42 U.S.C. 1320 c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. The DBPM 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.

viii. All subcontracts must provide for termination of the subcontract, or specify other remedies, when the LDH or DBPM determines that the subcontractor has not performed satisfactorily. The DBPM shall provide written notification to LDH of its intent to terminate any provider subcontract that may materially impact the DBPM'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 DBPM shall provide immediate written notice to the provider.

ix. If termination is related to network access, the DBPM shall include in the notification to LDH their plans to notify DBPM members of such change and strategy to ensure timely access to DBPM members through out-of-network providers. If termination is related to the DBPM's operations, the notification shall include the DBPM's plan for how it will ensure that there will be no stoppage or interruption of services to member or providers.

x. The DBPM 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 DBPM 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)(1).

xi. All subcontracts executed by the DBPM pursuant to this section shall, at a minimum, include the terms and conditions listed in Section I.3.10.k("Subcontract Requirement"). No other terms or conditions agreed to by the DBPM and its subcontractor shall negate or supersede the requirements in Section I.F.

l) Provider-Member Communication Anti-Gag Clause.

i. In accordance with 42 CFR §438.102, the DBPM shall not prohibit or otherwise restrict a healthcare provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the Contract, for the following:

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Any information the member needs in order to decide among relevant treatment options;
- The risks, benefits and consequences of treatment or non-treatment; and
- The member's right to participate in decisions regarding their healthcare, including, the right to refuse treatment, and to express preferences about future treatment decisions.

ii. Any DBPM that violates the anti-gag provisions set forth in 42 CFR §438.102 shall be subject to intermediate sanctions.

iii. The DBPM 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 Provider Incentive Plans.

m) Indians, Indian Healthcare Providers Network and coverage requirements.

i. The DBPM shall demonstrate that there are sufficient Indian Health Care Providers (ICHP) participating in the provider network of the Plan to ensure timely access to services available under the Contract from such providers for Indian enrollees who are eligible to receive services.

ii. The DBPM shall pay IHCPs, whether participating or not, for covered services provided to Indian enrollees who are eligible to receive services from such providers as follows:

- At a rate negotiated between the DBPM and the IHCP, or
- In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the DBPM would make for the services to a participating provider which is not an IHCP; and
- Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 C.F.R. § 447.45 and § 447.46.

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

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

v. If timely access to covered services cannot be ensured due to few or no IHCPs, the Plan shall be considered to have met the requirement in paragraph 1.3.1.6.3.1(1) of this section if--

- Indian enrollees are permitted by the Plan to access out of-State IHCPs; or
- If this circumstance is deemed to be good cause for disenrollment from both the Plan and the State's managed care program in accordance with § 438.56(c).

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

vii. An IMCE may restrict its enrollment to Indians in the same manner as Indian Health Programs, as defined in 25 U.S.C. § 1603(12), may restrict the delivery of services to Indians, without being in violation of the requirements in 42 C.F.R. § 438.3(d).

11. Utilization Requirements

a) <u>General Requirements</u>

i. The DBPM 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, which include, at minimum, procedures to evaluate medical necessity and the process used to review and approve the provision of dental services. The DBPM shall submit an electronic copy of the UM policies and procedures to LDH for written approval annually, and prior to any revisions.

ii. The UM Program policies and procedures shall meet all Utilization Review Accreditation Commission (URAC) standards or equivalent and include medical management criteria and practice guidelines that:

- Are adopted in consultation with a contracting dental care professionals;
- Are objective and based on valid and reliable clinical evidence or a consensus of dental care professionals in the particular field;
- Are considering the needs of the members; and
- Are reviewed annually and updated periodically as appropriate

iii. The policies and procedures shall include, but not be limited to:

- The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of dental care services;

- The data sources and clinical review criteria used in decision making;
- The appropriateness of clinical review shall be fully documented;
- The process for conducting informal reconsiderations for adverse determinations;
- Mechanisms to ensure consistent application of review criteria and compatible decisions;
- Data collection processes and analytical methods used in assessing utilization of dental care services; and
- Provisions for assuring confidentiality of clinical and proprietary information.

iv. The DBPM shall disseminate the practice guidelines to all affected providers and, upon request, to members. The DBPM shall take steps to encourage adoption of the guidelines.

v. The DBPM must identify the source of the dental management criteria used for the review of service authorization requests, including but not limited to:
- The vendor must be identified if the criteria were purchased;
- The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state dental care provider association or society;
- The guideline source must be identified if the criteria are based on national best practice guidelines; and
- The individuals who will make medical necessity determinations must be identified if the criteria are based on the dental/medical training, qualifications, and experience of the DBPM Dental Director or other qualified and trained professionals.

vi. UM Program dental management criteria and practice guidelines shall be disseminated to all affected providers, and 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.

vii. The DBPM shall have written procedures listing the information required from a member or dental care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or healthcare provider when requested. The procedures shall outline the process to be followed in the event the DBPM determines the need for additional information not initially requested.

viii. The DBPM 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 DBPM may deny authorization of the requested service(s).

ix. The DBPM shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines

x. The DBPM shall use LDH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37,

Number 1) for medical necessity determinations. The DBPM shall make medical necessity determinations that are consistent with the State's definition.

xi. The DBPM shall submit written policies and processes for LDH approval, on how the core dental benefits and services the DBPM provides ensure:

- The prevention, diagnosis, and treatment of health impairments;
- The ability to achieve age-appropriate growth and development; and
- The ability to attain, maintain, or regain functional capacity.

xii. The DBPM must identify the qualification of staff who will determine medical necessity.

xiii. Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.

xiv. The DBPM 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.

xv. 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.

xvi. The individual making these determinations is required to attest that no adverse determination will be made regarding any dental procedure or service outside of the scope of such individual's expertise.

xvii. The DBPM shall provide a mechanism to reduce inappropriate and duplicative use of healthcare services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The DBPM 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 DBPM may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.

xviii. The DBPM 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.

xix. The DBPM shall report fraud and abuse information identified through the UM program to LDH's Program Integrity Unit in accordance with 42 CFR §455.1(a)(1).

xx. The DBPM Utilization Review 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:

- Identification of the enrollee;
- The name of the enrollee's dentist;
- Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;
- The plan of care;
- Date of operating room reservation, if applicable; and
- Justification of emergency admission, if applicable.

b) Utilization Management Committee

i. The UM program shall include a Utilization Management (UM) Committee that integrates with other functional units of the DBPM as appropriate and supports the QAPI Program (refer to the Quality Management subsection for details regarding the QAPI Program).

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

- Monitoring providers' requests for rendering healthcare services to its members;
- Monitoring the dental appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling;
- Reviewing the effectiveness of the utilization review process and making changes to the process as needed;
- Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;
- Monitoring consistent application of "medical necessity" criteria;
- Application of clinical practice guidelines;
- Monitoring over- and under-utilization;
- Review of outliers, and
- Dental Record Reviews.

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

iv. The DBPM shall maintain a written strategy for conducting dental record reviews, reporting results, and the corrective

action process. The strategy shall be provided within thirty (30) calendar days from the date the Contract is signed by the DBPM 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 DBPM shall use to review each site; and
- How the DBPM shall link the information compiled during the review to other DBPM functions (*e.g.,* QI, credentialing, peer review, etc.)

v. The DBPM shall conduct reviews at all primary dental services providers that have treated more than 100 unduplicated members in a calendar year, including individual offices and large group facilities. The DBPM shall review each site at least one (1) time during each five (5) year period.

vi. The DBPM shall review a reasonable number of records, in a random process, at each site to determine compliance. Five (5) to ten (10) records per site is a generally accepted target, though additional reviews shall be completed for large group practices or when additional data is necessary in specific instances

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

c) Utilization Management Reports

The DBPM shall submit reports as specified by LDH. LDH reserves the right to request additional reports as deemed by LDH. LDH will make every effort the DBPM of additional required reports no less than 30 calendar days prior to due date of those reports. However, there may be occasions the DBPM will ports in a shorter time frame.

d) Service Authorization

i. Service authorization includes, but is not limited to, prior authorization.
ii. The DBPM UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210 and state laws and regulations and the court-ordered requirements of *Chisholm v. Gee* and *Wells v. Gee* for initial and continuing authorization of services that include, but are not limited to, the following:

- The DBPM shall notify the provider and give the enrollee written notice to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- The DBPM shall not require authorization for payment of primary and preventive dental care services furnished by a contracted provider.
- The DBPM shall not require service authorization for emergency dental services as described in this Section whether provided by an in-network or out-of-network provider.
- The DBPM shall not require service authorization or referral for EPSDT dental screening services.

- The DBPM shall not require service authorization for the continuation of covered services of a new enrollee transitioning into the DBPM or transitioning from the prior contracted DBPM, regardless of whether such services are provided by an in-network or out-of-network provider; however, the DBPM may require prior authorization of services beyond thirty (30) calendar days.
- The DBPM shall have automated authorization systems and may not require paper authorization as a condition of providing treatment.
- The DBPM shall not delay service authorization if written documentation is not available in a timely manner. However, the DBPM is not required to approve claims for which it has received no written documentation.
- The DBPM's service authorization system shall have capacity to electronically store and report all service authorization requests, decisions made by the DBPM regarding the service requests, clinical data to support the decision, and time frames for notification to providers and enrollees of decisions.
- The DBPM's service authorization systems shall provide the authorization number and effective dates for authorization to providers and non-participating providers.

iii. The DBPM shall not deny continuation of higher level services for failure to meet medical necessity unless the DBPM can provide the service through an in-network or out-of-network provider for a lower level of care.

iv. Practice Guidelines/Evidence-based Criteria

- The DBPM shall adopt practice guidelines that meet the following requirements:
  - Are based on valid and reliable clinical evidence or a consensus of dental professionals;
  - Consider the needs of the enrollee;
  - Are adopted in consultation with providers; and
  - Are reviewed and updated periodically, as appropriate.
- The DBPM must identify the source of the dental management criteria used for the review of service authorization requests, including but not limited to:
  - The vendor must be identified if the criteria were purchased;
  - The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state dental care provider association or society; and
  - The guideline source must be identified if the criteria are based on national best practice guidelines.
  - The DBPM shall disseminate any revised practice guidelines to all affected providers and, upon request, to enrollees.
- The DBPM shall ensure consistency with regard to all decisions relating to UM, enrollee education, covered services, and other areas to which the practice guidelines apply.

v. Clinical Decision-Making

- The DBPM shall ensure that all decisions to deny a service authorization request, or limit a service in amount, duration, or scope that is less than requested, must be:
    - Made by a licensed dentist, as appropriate, or other professional as approved by LDH, who has appropriate clinical experience in treating the enrollee's condition; and
    - Determined using the acceptable standards of care, state and federal laws, LDH's medical necessity definition, and clinical judgment of a licensed dentist, as appropriate, or other professional as approved by LDH.
- 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.
- The individual making these determinations is required to attest that no adverse benefit determination will be made regarding any dental procedure or service outside of the scope of such individual's expertise.

e) Timing of Service Authorization Decisions

i. The DBPM shall comply with the following standards, measured on a monthly basis, for processing authorization requests in a timely manner:

- The DBPM shall process ninety-five percent (95%) of all standard authorizations within ten (10) calendar days and one hundred percent (100%) in fourteen (14) calendar days.
- The DBPM shall process ninety-five percent (95%) of all expedited authorizations within two (2) business days and one hundred percent (100%) in three (3) calendar days.
- The DBPM shall submit a monthly report of the authorization timelines standards to LDH in a format specified by LDH

ii. Service Authorization Standards for Decisions

The DBPM shall notify the provider and give the enrollee written notice to deny a service authorization request, or

to authorize a service in an amount, duration, or scope that is less than requested.

The DBPM shall comply with the following standards, measured on a monthly basis, for notifying providers and enrollees in a timely manner:

- The DBPM shall provide standard authorization decisions within no more than fourteen (14) calendar days following receipt of the request for service.
- The DBPM may extend the timeframe for standard authorization decisions up to fourteen (14) additional calendar days, if the enrollee or the provider requests extension, or the DBPM justifies the need for additional information and how the extension is in the enrollee's interest.
- The DBPM shall provide expedited authorization decisions within no later than seventy-two (72) hours following receipt of the request for service.
- The DBPM may extend the timeframe for expedited authorization decisions up to fourteen (14) additional calendar days, if the enrollee or the provider requests extension, or the DBPM justifies the need for additional information and how the extension is in the enrollee's interest.

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

- Notify the enrollee of the reason for extending the timeframe and advising of the right to file a grievance if the enrollee disagrees with the extension of time;
- Issue and carry out its determination as expeditiously as possible but no later than the date the extension expires; and
- Send notice of the extension to the enrollee within five (5) business days of determining the need for an extension.

iii. Notice of Adverse Benefit Determination

- The DBPM shall notify the enrollee in writing using language that is easily understood, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other adverse benefit determination as defined in the contract. The notice to enrollees shall be consistent with federal regulations and requirements in the contract and approved by LDH.
- The DBPM shall include an identifying number on each notice of adverse benefit determination in a manner prescribed by LDH.
- The DBPM shall mail the notice of adverse benefit determination as follows:
    - For termination, suspension or reduction of previously authorized covered services no later than ten (10) days before the adverse benefit determination is to take effect;
    - By the date of the action when any of the following occur:

- The enrollee has died.
- The enrollee submits a signed, dated, written statement requesting service termination that includes information that requires service termination or reduction and indicates that he or she understands that the service termination or reduction will result.
- The enrollee has been admitted to a facility where he or she is ineligible under the DBPM for further services.
- The enrollee's whereabouts is determined unknown based on returned mail with no forwarding address.
- The enrollee is accepted for Medicaid services by another state.
- The enrollee's dentist or specialty dental provider prescribes a change in the level of dental care.

- For denial of payment, at the time of any adverse benefit determination affecting the clean claim; and

- For service authorization decisions not reached within required timeframes, on the date the timeframes expire. Such failures constitute a denial and are, therefore, an adverse benefit determination.

iv. Content of Notice of Adverse Benefit Determination

- The Notice of Adverse Benefit Determination must explain the following:
  - The action the DBPM or its subcontractor has taken or intends to take;
  - The reasons for the action;
  - The enrollee's right to file an appeal with the DBPM;
  - The enrollee's right to request a State Fair Hearing, after the DBPM's appeal process has been exhausted;
  - The procedures for exercising the rights specified in this Section;
  - The circumstances under which expedited resolution is available and how to request it; and
  - The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to repay the costs of these services.

v. Timing of Notice of Action

- The DBPM must mail the Notice of Action within the following timeframes:

    - For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) business days before the date of action, except when the period of advanced notice is shortened to five (5) business days if probable enrollee fraud has been verified by the date of the action for the following:
        - In the death of an enrollee;
        - A statement signed by the enrollee requesting service termination or giving information requiring termination or reduction of services;
        - The enrollee's admission to an institution where he or she is ineligible for further services;
        - The enrollee's address is unknown and mail directed to him or her has no forwarding address;
        - The enrollee is receiving Medicaid services in another state; or
        - The enrollee's dentist prescribes a change in the level of dental care.
- For denial of payment, at the time of any action affecting the claim

vi. Post Authorization

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

- Informal Reconsideration

    - As part of the DBPM appeal procedures, the DBPM shall include an Informal Reconsideration process that allows the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

    - In a case involving an initial determination, the DBPM shall 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 dentist or clinical peer making the adverse determination.

    - The informal reconsideration should occur within one (1) business day of the receipt of the request and

should be conducted between the provider rendering the service and the DBPM's dentist authorized to make adverse determinations or a clinical peer designated by the Dental Director if the dentist who made the adverse determination cannot be available within one (1) business day. The Informal Reconsideration will in no way extend the 30 day required timeframe for a Notice of Appeal Resolution.

- Exceptions to Requirements
  - The DBPM shall not require service authorization for emergency dental services as described in this Section whether provided by an in-network or out-of-network provider.
  - The DBPM shall not require service authorization or referral for EPSDT dental screening services.
  - The DBPM shall not require service authorization for the continuation of covered services of a new member transitioning into the DBPM, regardless of whether such services are provided by an in-network or out-of-network provider, however, the DBPM may require prior authorization of services beyond thirty (30) calendar days.

f) Primary Care Dentist Utilization and Quality Profiling

i. The DBPM shall profile its primary care dentists and analyze utilization data to identify primary care dentist utilization and/or quality of care issues.

ii. The DBPM shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.

iii. LDH reserves the right to request additional reports as deemed necessary. LDH will make every effort to notify the DBPM of additional required reports whether profile report or other reports, no less than sixty (60) calendar days prior to due date of those reports. However, there may be occasions the DBPM will be required to produce reports in a shorter timeframe.

g) Provider Payments

i. The DBPM shall profile its primary care dentists and analyze utilization data to identify primary care dentist utilization and/or quality of care issues.

ii. Minimum Reimbursement to In-Network Providers
- The DBPM shall provide reimbursement for defined core dental benefits and services provided by an in-network provider. The DBPM rate of reimbursement shall be no less than the published Medicaid fee-for-service rate in effect on July 1, 2013, unless LDH has granted an exception for a provider- initiated alternative payment arrangement.
- The network provider may enter into alternative reimbursement arrangements with the DBPM if the network provider agrees to the arrangement.

iii. FQHC/RHC Contracting and Reimbursement

- The DBPM must offer to contract for dental services, if applicable, with all FQHCs and RHCs in its service area. If an agreement cannot be reached between the DBPM and FQHC/RHC, the DBPM shall inform LDH.
- The DBPM may stipulate that reimbursement will be contingent upon receiving a clean claim.
- The DBPM shall reimburse an FQHC/RHC the Prospective Payment System (PPS) rate or Alternative Payment Date in effect on the date of service for each encounter.

iv. Reimbursement to Out-of-Network Providers

The DBPM shall make prompt payment for covered emergency dental services that are furnished by providers that have no arrangements with the DBPM for the provision of such services. In compliance with Section 6085 of the Deficit Reduction Act (DRA) of 2005, reimbursement by the DBPM to out-of-network providers for the provision of emergency dental services shall be no more than what would be paid under Medicaid FFS by LDH.

v. Claims Processing Requirements

- All provider claims that are clean and payable must be paid according to the following timeframes:
  - Within five (5) business days of receipt of a claim, the DBPM shall perform an initial screening, and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication.
  - Process and pay or deny, as appropriate, at least ninety percent (90%) of all clean claims for each claim type, within fifteen (15) business days of receipt.
  - Process and pay or deny, as appropriate, one hundred percent (100%) of all clean claims for each claim type, within thirty (30) calendar days of the date of receipt.

- At a minimum, the DBPM shall run one (1) provider payment cycle per week, on the same day each week, as determined by the DBPM. The DBPM and its subcontractors may, but mutual agreement, establish an alternative payment schedule.
- The DBPM shall support an Automated Clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.
- The DBPM 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 837), *i.e.,* electronic claims. As part of this Electronic Claims Management (ECM) function, the DBPM shall also provide on-line and phone-based capabilities to obtain claims processing status information.
- The DBPM shall generate Explanation of Benefits (EOBs) and Remittance Advices (RAs) in accordance with LDH standards for formatting, content and timeliness.
- The DBPM 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 DBPM shall not pay any claim

submitted by a provider that is on payment hold under the authority of LDH or its authorized agent(s).

- Not later than the fifteenth (15th) business day after the receipt of a provider claim that does not meet clean claim requirements, the DBPM shall pend the claim and request in writing (notification via email, the DBPM Website/Provider Portal or an interim Explanation of Benefits satisfies this requirement) all outstanding information such that the claim can be deemed clean. After receipt of the requested information from the provider, the DBPM must process the claim within fifteen (15) business days of the date of receipt (the date the DBPM receives the claim as indicated by the date stamp on the claim).
- Claims denied for additional information must be closed (paid or denied) by the thirtieth (30th) calendar day following the date the claim is denied if all requested information is not received prior to the expiration of the 30-day period. The DBPM shall send providers written notice (notification via email, the DBPM Website/Provider Portal or an Explanation of Benefits satisfies this requirement) for each claim that is denied, including the reason(s) for the denial and the date the DBPM received the provider to adjudicate the claim.
- The DBPM 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 adjudicated.
- The DBPM must deny any claim not initially submitted to the DBPM by the three hundred and sixty-fifth (365th) calendar day from the date of service, unless the DBPM or its vendors created the error. If a provider files erroneously with LDHs FI, but produces documentation verifying that the initial filing of the claim occurred within the three hundred and sixty-five (365) calendar day period, the DBPM shall process the provider's claim without denying for failure to timely file.
- The DBPM shall inform all network providers about the information required to submit a clean claim. The DBPM shall make available to network providers claims coding and processing guidelines for the applicable provider type. The DBPM shall notify providers ninety (90) calendar days before implementing changes to claims coding and processing guidelines.
- In addition to the specific Website requirements outlined above, the DBPM's Website shall be functionally equivalent to the Website maintained by LDH's FI.
- For the purposes of DBPM reporting on payments 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.

vi. Inappropriate Payment Denials

If the DBPM has a pattern of inappropriately denying or delaying provider payments for services, the DBPM 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 LDH has ordered payment after appeal but to situations where no appeal has been made

(*i.e.,* LDH is knowledgeable about the documented abuse from other sources).

vii. Payment for Emergency Dental Services

- The DBPM shall reimburse providers for emergency dental services rendered without a requirement for service authorization of any kind.
- The DBPM's protocol for provision of emergency dental services must specify that emergency dental services will be covered when furnished by a provider with which the DBPM does not have a subcontract or referral arrangement.
- The DBPM may not limit what constitutes an emergency dental condition on the basis of diagnoses or symptoms or refuse to cover emergency dental services based on the provider notifying the member's primary dentist of the member's screening and treatment within ten (10) calendar days of presentation for emergency dental services.
- The DBPM shall not deny payment for treatment when a representative of the DBPM instructs the member to seek emergency dental services.
- The DBPM shall not deny payment for treatment obtained when a member had an emergency dental condition and the absence of immediate medical attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of emergency dental condition.
- The DBPM shall be financially responsible for emergency dental services and shall not retroactively deny a claim for emergency dental services to a provider because the condition, which appeared to be an Emergency Dental Condition under the prudent layperson standard, was subsequently determined to be non-emergency in nature.
- Expenditures for emergency dental services as previously described must be factored into the capitation rate described in this contract and the DBPM will not be entitled to receive any additional payments.

viii. Provider Incentive Plans

- Provider Incentive Plans (PIPs) must comply with requirements for physician incentive plans in 42 CFR §§417.479, 422.208, 422.210, 438.3(i) and 438.6(h). Specific payment cannot be made directly or indirectly under a Provider Incentive Plan to a dentist or dentist group as an inducement to reduce or limit medically necessary services furnished to an individual.
- The DBPM shall submit any information regarding incentives as may be required by LDH. The DBPM shall receive approval from LDH prior to implementation of the PIP.

    - The DBPM shall receive prior LDH approval of the Provider Incentive Plan and shall submit to LDH any contract templates that involve a PIP for review as a material modification. The DBPM shall disclose the following:

        - Services that are furnished by a dentist/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 dentist/group is at substantial financial risk, the entity must report proof the dentist/group has adequate stop loss coverage, including amount and type of stop-loss.

- The DBPM shall conduct periodic surveys of current and former enrollees where substantial financial risk exists (as specified in 42 CFR §422.208(h). A summary of the results must be provided to any beneficiary who requests it (as specified in 42 CFR §422.210(b)).
- The DBPM shall provide information on its incentive plans to any Medicaid member upon request (this includes the right to adequate and timely information on the plan).

ix. IHCP Payment requirements.

- When an IHCP is enrolled in Medicaid as a FQHC but not a participating provider of the DBPM, the DBPM shall pay the IHCP at an amount equal to the amount the IHCP would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from the State to make up the difference between the amount the DBPM pays and what the IHCP FQHC would have received under FFS.
- When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of the DBPM or not, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's FFS payment methodology. In such case, the DBPM shall pay the IHCP the rate the IHCP is entitled to.
- When the amount a IHCP receives from the DBPM is less than the amount required by paragraph 2 of this section, the State must make a supplemental payment to the IHCP to make up the difference between the amount the DBPM pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

x. Dental Full Medicaid Payment (FMP)

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

h) <u>Provider Services</u>

i. Provider Relations

- The DBPM shall, at a minimum, provide a Provider Relations function to provide support and assistance to all providers in their DBPM network. This function shall:

  - Be available Monday through Friday from 7:00 am to 5:00 pm Central Time to address non-emergency provider issues or requests;

- Provide ongoing provider training, respond to provider inquiries and provide general assistance to providers regarding program operations and requirements; and
- Ensure regularly scheduled visits to provider sites, as well as ad hoc visits as circumstances dictate.

ii. Provider Toll-free Telephone Line

- The DBPM must operate a toll-free telephone line to respond to provider questions, comments and inquiries.
- The provider access component of the toll-free telephone line must be staffed between the hours of 7:00 am-5:00 pm Central Time Monday through Friday to respond to provider questions in all areas, including but not limited to prior authorization requests, provider appeals, provider processes, provider complaints, and regarding provider responsibilities.
- The DBPM's call center system must have the capability to track provider call management metrics.
- After normal business hours, the provider service component of the toll-free telephone line must include the capability of providing information regarding normal business hours and instructions to verify enrollment for any DBPM member with an emergency or urgent dental condition. This shall not be construed to mean that the provider must obtain verification before providing emergency/urgent care.
- The DBPM shall report on and meet the following provider call center performance standards, on a monthly basis.
- Answer ninety percent (90%) of calls within thirty (30) seconds by a live person or direct the call to an automatic call pickup system with IVR options;
- Maintain an average hold time (the time a caller spends waiting to speak to a live person, once requested) of three (3) minutes or less; Hold time, or wait time, for the purposes of this contract includes 1) the time a caller spends waiting for a customer service representative to assist them after the caller has navigated the IVR system and requested a live person, and 2) the measure of time when a customer service representative places a caller on hold.
- Maintain abandoned rate of calls of not more than five percent (5%).
- The DBPM must conduct ongoing quality assurance to ensure these standards are met.
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iii. Provider Website

- The DBPM shall have a provider website. The provider website may be developed on a page within the DBPM's existing website (such as a portal) to meet these requirements.
- The DBPM provider website shall include general and up-to-date information about the DBPM as it relates to the Louisiana program. This shall include, but is not limited to:

  - DBPM provider manual;
  - DBPM-relevant LDH bulletins;
  - Information on upcoming provider trainings;
  - A copy of the provider training manual;
  - Information on the provider complaint and dispute system;

- Information on obtaining prior authorization and referrals; and
- Information on how to contact the DBPM Provider Relations.

- The DBPM provider website is considered marketing material and, as such, must be reviewed and approved by LDH in writing.
- The DBPM must notify LDH when any approved changes are made.
- The DBPM must remain compliant with HIPAA privacy and security requirements when providing any member eligibility or member identification information on the website.
- The DBPM 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.

iv. Provider Handbook

- The DBPM shall develop and issue a provider handbook.
- The DBPM 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 DBPM's website. This notification shall also detail how the provider can request a hard copy from the DBPM at no charge to the provider.
- 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 DBPM covered services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all DBPM requirements are met.
- At a minimum, the provider handbook shall include the following information:

  - Description of the DBPM;
  - Core dental benefits and services the DBPM must provide;
  - Emergency dental service responsibilities;
  - 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 DBPM to file a provider complaint and which individual(s) has the authority to review a provider complaint;
  - Information about the DBPM's Grievance System, that the provider may file a grievance or appeal on behalf of the member with the member's written consent, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers and the member's right to request continuation of services while utilizing the grievance system;
  - Medical necessity standards as defined by LDH and practice guidelines;
  - Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;
  - Primary care dentist responsibilities;
  - Other provider responsibilities under the subcontract with the DBPM;
  - Prior authorization and referral procedures;
  - Dental records standards;

- Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims;
- DBPM prompt pay requirements;
- Notice that provider complaints regarding claims payment shall be sent to the DBPM;
- Quality performance requirements; and
- Provider rights and responsibilities.

- The DBPM shall disseminate bulletins as needed to incorporate any changes to the provider handbook.

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

vi. Provider Complaint System
- The DBPM shall establish a Provider Complaint System for in-network and out-of-network providers to dispute the DBPM's policies, procedures, or any aspect of the DBPM's administrative functions.
- Applicable Definitions
  - **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 DBPM, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by the DBPM, 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.
  - **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 this contract; or
    - The failure of the DBPM to act within the timeframes provided in this contract.
- The DBPM 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.

- This system must be capable of identifying and tracking complaints received by phone, in writing, or in person, on any issue that expresses dissatisfaction with a policy, procedure, or any other communication or action by the DBPM.
- As part of the Provider Complaint system, the DBPM shall:

  - 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;
  - Identify a staff person specifically designated to receive and process provider complaints;
  - Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties and applying the DBPM's written policies and procedures; and
  - Ensure that DBPM executives with the authority to require corrective action are involved in the provider complaint process as necessary.

- The DBPM shall have and implement written policies and procedures which detail the operation of the Provider Complaint System. Provider complaints must be acknowledged within three business days. Provider complaints must resolved as soon as feasible, but within no more than thirty calendar days unless both the provider and LDH have been notified of the outstanding issue, and provided a timeline of resolution and reason for the extension of time. All complaints should be resolved in no more than ninety days. The policies and procedures shall include, at a minimum:

  - Allowing providers thirty (30) calendar days to file a written complaint and a description of how providers file complaint with the DBPM and the resolution time;
  - A description of how and under what circumstances providers are advised that they may file a complaint with the DBPM for issues that are DBPM Provider Complaints and under what circumstances a provider may file a complaint directly to LDH/MMIS for those decisions that are not a unique function of the DBPM;
  - A description of how provider relations staff are trained to distinguish between a provider complaint and an member grievance or appeal in which the provider is acting on the member's behalf with the member's written consent;
  - 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;
  - A process for thoroughly investigating each complaint using applicable sub-contractual provisions, and for collecting pertinent facts from all parties during the investigation;
  - A description of the methods used to ensure that DBPM executive staff with the authority to require corrective

action are involved in the complaint process, as necessary;
- A process for giving providers (or their representatives) the opportunity to present their cases in person;
- Identification of specific individuals who have authority to administer the provider complaint process;
- 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
- A provision requiring the DBPM to report the status of all provider complaints and their resolution to LDH on a monthly basis in the format required by LDH.

- The DBPM shall include a description of the Provider Complaint System in the Provider Handbook and include specific instructions regarding how to contact the DBPM's Provider Relations staff; and contact information for the person from the DBPM who receives and processes provider complaints.

- The DBPM shall distribute the DBPM's policies and procedures to in-network providers at time of subcontract and to out-of-network providers with the remittance advice. The DBPM may distribute a summary of these policies and procedures to providers if the summary includes information about how the provider may access the full policies and procedures on the DBPM's website. This summary shall also detail how the in-network provider can request a hard copy from the DBPM at no charge to the provider.

i) <u>Enrollment and Disenrollment</u>

i. Enrollment

- The Medicaid Fiscal Intermediary (FI) shall provide Louisiana Medicaid beneficiary information to the DBPM via an electronic file transfer, hereafter referred to as the "Member File". The DBPM will utilize the Member File to identify all individuals eligible for enrollment, based on predetermined eligibility criteria as outlined in this contract. The DBPM's responsibilities subsequent to eligibility determination will include, but will not necessarily be limited to, the following:

  - DBPM staff shall be available by telephone as appropriate to provide assistance to DBPM potential members, and educating the Medicaid eligible about the DBP in general, including the manner in which services typically are accessed under the DBPM, the role of the primary care dentist, the responsibilities of the DBPM member, his/her right to file grievances and appeals, and the rights of the member to choose any primary care dentist within the DBPM, subject to the capacity of the provider;
  - Educating the member, or in the case of a minor, the member's parent or guardian, about benefits and services available through the DBP.; and

- Identifying any barriers to access to care for the DBP members such as the necessity for multi-lingual interpreter services and special assistance needed for members with visual and hearing impairment and members with physical or mental disabilities.

ii. Enrollment Procedures

- Effective Date of Enrollment
  DBPM enrollment for members in a given month will be effective at 12:01 AM on the first (1st) calendar day of the month of Medicaid eligibility. The DBPM must accept all individuals assigned to it by the FI in the order in which they are assigned without restriction. 42 CFR §438.3(d)

- Change in Status
  The DBPM agrees to report in writing to LDH'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, email address, telephone number and insurance coverage.

- Assignment of Primary Care Dentists

  - The DBPM shall encourage the continuation of any existing satisfactory provider/patient relationship with current primary care dentists participating in the DBPM.
  - The DBPM shall contact the member, as part of the welcome process, within ten (10) business days of receiving the Member File from the FI to assist the member in making a selection of a primary care dentist. The DBPM shall confirm the primary care dentist selection information in a written notice to the member.
  - If no primary care dentist is selected by the member, the DBPM shall inform the member that each family member has the right to choose his/her own primary care dentist. The DBPM may explain the advantages of selecting the same primary care dentist for all family members, as appropriate.
  - Members, for whom the DBPM is the primary payor, who do not proactively choose a primary care dentist DBPM will be auto-assigned to a primary care dentist by the DBPM. Members, for whom the DBPM is the secondary payor, will not be assigned to a primary care dentist by the DBPM, unless the members request that the DBPM do so.
  - The DBPM shall have written policies and procedures for handling the assignment of its members to a primary care dentist. The DBPM is responsible for linking to a primary care dentist all assigned DBPM members for whom the DBPM is the primary payor.

- Primary Care Dentist Auto-Assignments

  - The DBPM is responsible for developing a primary care dentist automatic assignment methodology in collaboration with LDH to assign a member for whom the DBPM is the primary payor to a primary care dentist when the member:

- Does not make a primary care dentist selection; or
- Selects a primary care dentist within the DBPM that has restrictions/limitations (*e.g.,* pediatric only practice).

- Assignment shall be made to a primary care dentist with whom, based on claims history or prior linkage, the member has a historical provider relationship. If there is no historical primary care dentist relationship, the member may be auto-assigned to a provider who is the assigned primary care dentist for an immediate family member enrolled in the DBPM. If other immediate family members do not have an assigned primary care dentist, auto-assignment shall be made to a provider with whom a family member has a historical provider relationship.
- If there is no member or immediate family historical usage, members shall be auto-assigned to a primary care dentist using an algorithm developed by the Contractor, based on the age and sex of the member and geographic proximity.
- The primary care dentist automatic assignment methodology must be approved by LDH and be made available via the DBPM's website, and Provider Handbook.
- The DBPM shall be responsible for providing to LDH, information on the number of Medicaid member linkages and remaining capacity of each individual primary care dentist of additional Medicaid member linkages on a quarterly basis.
- If the member does not select a primary care dentist and is auto assigned to a primary care dentist by the DBPM, the DBPM shall allow the member to change primary care dentist.
- If a member requests to change his or her primary care dentist, at any time, the DBPM may agree to grant this request for good cause.
- The DBPM shall have written policies and procedures for allowing members to select a new primary care dentist, including auto-assignment, and provide information on options for selecting a new primary care dentist when it has been determined that a primary care dentist is non-compliant with provider standards (*i.e.,* quality of care) and is terminated from the DBPM, or when a primary care dentist change is ordered as part of the resolution to a grievance proceeding, The DBPM shall allow members to select another primary care dentist within ten (10) business days of the postmark date of the termination of primary care dentist notice to members and provide information on options for selecting a new primary care dentist.
- The DBPM shall have policies for accessing emergency/urgent care during this transition period.

- Disenrollment

  Disenrollment is any action taken by LDH or its designee to remove a DBPM member from the DBPM following the receipt and approval of a written request for disenrollment or a determination made by LDH or its designee that the member is no longer eligible for Medicaid or the DBP.

LDH will notify the DBPM of the member's disenrollment due to the following reasons:

- Loss of Medicaid eligibility or loss of DBP enrollment eligibility;
- Death of a member;
- Member's intentional submission of fraudulent information;
- Member becomes an inmate in a public institution;
- Member moves out-of-state;
- To implement the decision of a hearing officer in an appeal proceeding by the member against the DBPM or as ordered by a court of law.

- Disenrollment Effective Date
  - 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 submitted.
  - If LDH or its designee fails to make a disenrollment determination by the first day of the second month following the month in which the request for disenrollment is submitted, the disenrollment is considered approved. The DBPM shall process all member file updates from the FI prior to the reconciliation process. Noncompliance with the reconciliation process may result in administrative sanctions.
  - LDH and the DBPM shall reconcile enrollment/disenrollment issues at the end of each month utilizing an agreed upon procedure.

- Enrollment and Disenrollment Updates
  - Daily Updates
    - The FI shall make available to the DBPM daily incremental Member File updates in the format specified in the Systems Companion Guide. The DBPM shall have written policies and procedures for receiving these updates, incorporating them into its management information system and ensuring this information is available to their providers. Policies and procedures shall be available for review.
    - LDH will use its best efforts to ensure that the DBPM receives timely and accurate information to determine DBPM membership. In the event of discrepancies or irresolvable differences between LDH and the DBPM regarding members eligible for enrollment, LDH's decision is final.

  - Weekly Reconciliation
    - Enrollment
      In addition to the daily Member File updates, the FI will also provide a full Member File to the DBPM on a weekly basis. The DBPM is responsible for reconciliation of the membership list derived from the weekly Member File received from the FI against its internal records. The DBPM shall provide written notification to the FI of any data inconsistencies within 10 calendar days of receipt of the data file.

    - Payment

The DBPM will receive monthly electronic file (ASC X12N 820 Transaction) from the FI listing all members for whom the DBPM received a capitation payment and the amount received. The DBPM is responsible for reconciling this listing against its internal records. It is the DBPM's responsibility to notify the FI of any discrepancies. Lack of compliance with reconciliation requirements will result in the withholding of portion of future monthly payments and/or monetary penalties as defined in this contract.

j) Member Education

i. General Guidelines

- Member education is defined as communication with an enrolled member of the DBPM.
- Member education can be both verbal and written.
- All member education guidelines are applicable to the DBPM, its agents, subcontractors, volunteers and/or providers.
- All 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.
- All member education materials and activities shall comply with the requirements in 42 CFR §438.10 and the LDH requirements set forth in this contract and the Dental Benefit Program Companion Guide.
  - In accordance with 42 CFR §438.10(b)(1), LDH shall provide the DBPM the prevalent non-English language spoken by enrollees in the state. Prevalent is defined as five percent of the population statewide.
  - The DBPM, as required in 42 CFR §438.10(c)(3), shall be responsible for providing to enrollees and potential enrollees written information in the prevalent non-English language in the DBPM's particular service area.
    In accordance with 42 CFR §438.10(c)(4)-(5), the DBPM shall provide enrollees oral interpretation services available free of charge, to all non-English languages rather than to only those LDH identifies as prevalent. The DBPM is responsible for providing all written materials in alternative formats, available through auxiliary aids and services and in a manner that considers the special needs of those who, for example, are visually limited or have limited reading proficiency.
- The DBPM is responsible for creation, production and distribution of its own member education materials to its members.
- All member education materials, in all mediums, must be reviewed and approved in writing by LDH or its designee in accordance with Social Security Act § 1932 (d)(2)(A) and 42 CFR §438.104.
- The DBPM shall assure LDH that member education materials are accurate and do not mislead, confuse, or defraud the member/potential member or LDH as specified in Social Security Act § 1932 (d) and 42 CFR §438.104.
- The DBPM shall participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members and comply with the Office of Minority Health, Department of Health and Human Services' "National Culturally and Linguistically Appropriate Services Standards

(National CLAS Standards)" at the following URL: https://www.thinkculturalhealth.hhs.gov/clas/standards and participate in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees. The DBPM must have a comprehensive written Cultural Competency Plan describing how the DBPM will ensure culturally competent services, and provide Linguistic Access and Disability-related Access. The plan must be developed in adherence to the National CLAS Standards.

- All member materials must be in a style and reading level that will accommodate the reading skills of 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 ensure accuracy:
    - Flesch – Kincaid;
    - Fry Readability Index;
    - PROSE The Readability Analyst (software developed by Educational Activities, Inc.);
    - Gunning FOG Index;
    - McLaughlin SMOG Index; or
    - Other computer generated readability indices accepted by LDH

ii. Marketing and Member Education Plan

- The DBPM shall develop and implement a plan detailing the member education activities it will undertake and materials it will create during the contract period. The detailed plan must approved by LDH.
- The DBPM shall not begin member education activities prior to the approval of the member education plan.
- The DBPM member education plan shall:
    - List any subcontractors engaged in member education activities for the DBPM;
    - State member education goals and strategies; and
    - Include the DBPM's plans to monitor and enforce compliance with all member education guidelines.
- Any changes to the member education plan or included materials or activities must be submitted to LDH for approval at least thirty (30) days before implementation of the member education activity, unless the DBPM can demonstrate just cause for an abbreviated timeframe.

iii. Member Education Materials Approval Process

- The DBPM must obtain prior written approval from LDH for all member education materials. This includes, but is not limited to, print, television and radio advertisements; handbooks, and provider directories; DBPM website screen shots; promotional items; brochures; letters and mass mailings and emails. Neither the DBPM nor its subcontractors may distribute any DBPM member education materials without LDH consent.
- The DBPM must obtain prior written approval for all materials developed by a recognized entity having no association with the DBPM that the DBPM wishes to distribute.

iv. Member Education – Required Materials and Services

The DBPM shall ensure that all materials and services do not discriminate against DBP members on the basis of their health history, health status, need for healthcare services. This applies to enrollment, re-enrollment or disenrollment materials and processes from the DBPM.

- Member Orientation

  - The DBPM shall have written policies and procedures for the following, but not limited to:

    - Orienting new members of its benefits and services;
    - Role of the primary care dentist;
    - What to do during the transition period;
    - How to utilize services;
    - What to do in a dental emergency or urgent dental situation; and
    - How to a file a grievance or appeal.

  - The DBPM shall identify and educate members who access the system inappropriately and provide continuing education as needed.
  - The DBPM may propose, for approval by LDH, alternative methods for orienting new members and must be prepared to demonstrate their efficacy.
  - The DBPM shall have written policies and procedures for notifying newly identified members within ten (10) business days after receiving the Member File from the FI. This notification must be in writing and include a listing of primary care dentist names (and include locations, and office telephone numbers) that the member may choose as their primary dental care provider.
  - The DBPM shall submit a copy of the procedures to be used to contact DBPM members for initial member education to LDH for approval. These procedures shall adhere to the process and procedures outlined in this contract.
  - New Medicaid eligibles who have not proactively selected a primary care dentist or whose choice of primary care dentist is not available will have the opportunity to select a primary care dentist within the DBPM that: 1) has entered into a subcontract with the DBPM; and 2) is within a reasonable commuting distance from their residence.

- Communication with New Members

  - LDH's FI shall send the DBPM a daily file in the format specified in the DBPM Systems Companion Guide. The file shall contain the names, addresses, and phone numbers of all newly eligible members, as determined by the DBPM. The DBPM shall use the file Member File to assign primary care dentists and to identify and initiate communication with new members via welcome packet mailings as prescribed in this contract.

- Welcome Packets

  - The DBPM shall send a welcome packet to new members within ten (10) business days from the date of receipt of the Member File from the FI.

- The DBPM must mail a welcome packet to each new member. When the name of the responsible party for the new member is associated with two (2) or more new members, the DBPM is only required to send one welcome packet.

- All contents of the welcome packet are considered member education materials and, as such, shall be reviewed and approved in writing by LDH prior to distribution according to the provisions described in this contract. Contents of the welcome packets shall include those items specified in the Contract. The welcome packet shall include, but is not limited to:

  - A welcome letter highlighting major program features and contact information for the DBPM; and
  - A Provider Directory when specifically requested by the member (also must be available in searchable format on-line).

- The DBPM shall adhere to the requirements for the Provider Directory as specified in this contract, the Dental Benefit Program Companion Guide, its attachments, and in accordance with 42 CFR §438.10 (h).

v. Member Identification (ID) Cards

- DBP members shall use their LDH issued Medicaid ID card to access benefits and services covered as part of the Dental Benefit Program. The DBPM will not provide members with a separate ID card.
- The LDH issued Medicaid ID card shall not be proof of eligibility, but can be used for accessing the state's electronic eligibility verification systems by DBPM providers. These systems will contain the most current information available to LDH, including specific information regarding DBP enrollment.

vi. Provider Directory for Members

- The DBPM shall develop and maintain a Provider Directory in two (2) formats:
  - Web-based, in a searchable machine readable file, online directory for members and the public; and
  - A hard copy directory for members upon request only;

- LDH or its designee shall provide the file layout for the electronic directory to the DBPM after approval of the Contract. The DBPM shall submit templates of its provider directory to LDH.
- The hard copy directory for members shall be reprinted with updates at least monthly for new members and to fulfill only requests. The web-based online version shall be updated in real time, however no less than weekly.
- In accordance with 42 CFR §438.10(h), the provider directory shall include, but not be limited to:

  - Names, as well as any group affiliations, locations, telephone numbers of, website URLs, as appropriate and non-English languages spoken by current contracted providers or skilled interpreter at the provider’s office in

the Medicaid enrollee's service area and whether the provider has completed cultural competence training, including identification of providers, primary care dentists, specialists, and providers that are not accepting new patients at a minimum;
- Identification of primary care dentists, specialists, and dental groups in the service area;
  - Whether network providers' offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment;
- Identification of any restrictions on the enrollee's freedom choice among network providers; and
- Identification of hours of operation including identification of providers with non-traditional hours (Before 8:00 a.m. or after 5:00 p.m. or any weekend hours).

vii. Member Call Center

- The DBPM shall maintain a toll-free member service call center, physically located in the United States, The member service lines shall be adequately staffed and individuals trained to accurately respond to questions regarding:
  - DBPM policies and procedures;
  - Prior authorizations;
  - Access information;
  - Information on primary care dentists or specialists;
  - Referrals to participating specialists;
  - Resolution of service and/or dental delivery problems; and
  - Member grievances.

- The toll-free number must be staffed between the hours of 7:00 a.m. and 7:00 p.m. Central Time, Monday through Friday.

  The toll-free line shall have an automated system, available 24-hours a day, and seven days a week, including all federal and state holidays. This automated system must include the capability of providing callers with operating instructions on what to do in case of a dental emergency and the option to leave a message, including instructions on how to leave a message and when that message will be returned. The DBPM must ensure that the voice mailbox has adequate capacity to receive all messages and that member services staff return all calls by close of business the following business day.

- The DBPM shall have sufficient telephone lines to answer incoming calls. The DBPM shall ensure sufficient staffing to meet performance standards listed in this contract. LDH reserves the right to specify staffing ratio and/or other requirements, if performance standards are not meet or it is determined that the call center staffing/processes are not sufficient to meet member needs as determined by LDH.

- The DBPM 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 DBPM performance. The DBPM must develop and implement a plan to sustain call center performance levels in situations where there is high call/email volume or low staff availability. Such

situations may include, but are not limited to, increases in call volume, emergency situations (including natural disasters such as hurricanes), staff in training, staff illnesses and vacations.

- The DBPM must develop telephone help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards. The DBPM shall submit these telephone help line policies and procedures, including performance standards, to LDH for written approval prior to implementation of any policies. This must include a capability to track and report information on each call. The DBPM 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.

- The DBPM shall develop call center quality criteria and protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the toll-free telephone line. The DBPM shall submit call center quality criteria and protocols to LDH for review and approval annually.

viii. Member Call Center Performance Standards

- The DBPM shall report on and meet the following member call center performance standards, on a monthly basis.
- Answer ninety percent (90%) of calls within thirty (30) seconds by a live person or direct the call to an automatic call pickup system with IVR options;
- No more than one percent (1%) of incoming calls receives a busy signal;
- Maintain an average hold time (the time a caller spends waiting to speak to a live person, once requested) of three (3) minutes or less; Hold time, or wait time, for the purposes of this contract includes 1) the time a caller spends waiting for a customer service representative to assist them after the caller has navigated the IVR system and requested a live person, and 2) the measure of time when a customer service representative places a caller on hold.
- Maintain abandoned rate of calls of not more than five percent (5%).
- The DBPM must conduct ongoing quality assurance to ensure these standards are met.
- If LDH determines that it is necessary to conduct onsite monitoring of the DBPM's member call center functions, the DBPM is responsible for all reasonable costs incurred by LDH or its authorized agent(s) relating to such monitoring.
- The DBPM shall have written policies regarding member rights and responsibilities. The DBPM shall comply with all applicable state and federal laws pertaining to member rights and privacy. The DBPM shall further ensure that the DBPM's employees, contractors and DBPM providers consider and respect those rights when providing services to members.

ix. ACD System

- The DBPM shall install, operate and monitor an automated call distribution (ACD) system for the customer service telephone call center. The ACD system shall:

- Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;
- Transfer calls to other telephone lines;
- Provide an option to speak to a live person (during call center hours of operation);
- 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;
- Provide a message that notifies callers that the call may be monitored for quality control purposes;
- Measure the number of calls in the queue at peak times;
- Measure the length of time callers are on hold;
- Measure the total number of calls and average calls handled per day/week/month;
- Measure the average hours of use per day;
- Assess the busiest times and days by number of calls;
- Record calls to assess whether answered accurately;
- Provide a backup telephone system that shall operate in the event of line trouble, emergency situations including natural disasters, or other problems so that access to the telephone lines is not disrupted;
- Provide interactive voice response (IVR) options that are user-friendly to members and include a decision tree illustrating IVR system; and
- Inform the member to dial 911 if there is an emergency.

x. Member Responsibilities

- The DBPM shall encourage each member to be responsible for his own healthcare 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 dental, medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their healthcare provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.
- The DBP members' responsibilities shall include but are not limited to:
  - Presenting their LDH issued Medicaid ID card when using healthcare services;
  - Being familiar with the DBP procedures to the best of the member's abilities;
  - Calling or contacting the DBPM to obtain information and have questions answered;
  - Providing participating network providers with accurate and complete dental 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 DBPM 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.

xi. Notice to Members of Provider Termination

- The DBPM shall 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.
- The DBPM shall provide notice to a member, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within ten (10) calendar days from the date the DBPM becomes aware of such, if it is prior to the change occurring.
- 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 DBPM, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the DBPM becoming aware of the circumstances. The DBPM shall document the date and method of notification of termination.

xii. Additional Member Educational Materials and Programs

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

xiii. Oral and Written Interpretation Services

- The DBPM must make interpretation services , including oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language (ASL), available free of charge to each potential member and member. Oral interpretation services shall be available in all non-English languages, not just those that Louisiana specifically requires (Spanish and Vietnamese). The member is not to be charged for interpretation services. The DBPM must notify its members that oral interpretation is available for any language and written information is available in Spanish and Vietnamese and how to access those services. On materials where this information is provided, the notation should be written in both Spanish and Vietnamese.
- The DBPM shall ensure that translation services are provided for written marketing and member education

materials for any language that is spoken as a primary language by more than five percent (5%) of the population statewide. Within 90 calendar days of notice from LDH, materials must be translated and made available. Materials must be made available at no charge in that specific language to ensure a reasonable chance for all members to understand how to access the DBPM and use services appropriately as specified in 42 CFR §438.10(c)(4) and (5).

xiv. Member Materials

The DBPM shall include in all member materials the following:

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

xv. Member and State Fair Hearing Procedures

- The DBPM must have a grievance system that complies with 42 CFR Part 438, Subpart F. The DBPM 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 DBPM's grievance and appeals procedures must be submitted for review and approval and any changes thereto must be approved in writing by LDH prior to their implementation and must include at a minimum the requirements set forth in this contract.
- The DBPM shall refer all DBP members who are dissatisfied with the DBPM or its subcontractor in any respect to the DBPM's designee authorized to review and respond to grievances and appeals and require corrective action
- The member must exhaust the DBPM's internal grievance/appeal procedures prior to accessing the State Fair Hearing process.
- The DBPM shall not create barriers to timely due process. The DBPM shall be subject to sanctions if it is determined by LDH that the DBPM has created barriers to timely due process or that ten percent (10%) or more of grievance decisions appealed to the State Fair Hearing level within a twelve (12) month period have been reversed or otherwise resolved in favor of the member. Examples of creating barriers shall include but not be limited to:
  - Labeling complaints 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
- The DBPM shall take no punitive action against a provider who either requests an expedited resolution or supports an enrollee's appeal. [42 CFR 438.410(b)]

xvi. General Grievance System Requirements

- Grievance System

The DBPM 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 DBPM's appeal process has been exhausted.

- Authority to File
  - A member, or authorized representative acting on the member's behalf, may file a grievance and a DBPM level appeal, and may request a State Fair Hearing, once the DBPM's appeals process has been exhausted.
  - 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.

- Time Limits for Filing
  The member must be allowed sixty (60) calendar days from the date on the DBPM's notice of action or inaction to file a grievance or appeal. Within that timeframe the member or a representative acting on their behalf may file an appeal or the provider may file an appeal on behalf of the member, and with the member's written consent.

- Procedures for Filing
  - The member may file a grievance either orally or in writing with the DBPM.
  - The DBPM's process for handling enrollee grievances must include acknowledgement in writing within five (5) business days of receipt of each grievance.
  - The DBPM shall review the grievance and provide written notice to the enrollee of the disposition of a grievance no later than ninety (90) calendar days from the date the DBPM receives the grievance.
  - The DBPM shall extend the timeframe of disposition for a grievance by up to fourteen (14) calendar days if:
    - The enrollee requests the extension; or
    - The DBPM shows (to the satisfaction of LDH, upon its request) that there is a need for additional information and how the delay is in the enrollee's interest.
  - If the timeframe is extended other than at the enrollee's request, the DBPM shall provide oral notice of the reason for the delay to the enrollee by close of business on the day of the determination, and written notice of the reason for the delay within two (2) calendar days of the determination.

xvii. Notice of Grievance and Appeal Procedures
The DBPM shall ensure that all DBP members are informed of the State Fair Hearing process and of the DBPM's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the DBPM shall be available through the DBPM, and must be provided upon request of the member. The DBPM shall make all forms easily available on the DBPM's website.

xviii. Grievance/Appeal Records and Reports

- The DBPM 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.

- The DBPM shall electronically provide LDH with a monthly report of the grievances/appeals in accordance with the requirements outlined in this contract, 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.
- The DBPM will be responsible for promptly forwarding any adverse decisions to LDH for further review/action upon request by LDH or the DBPM member. LDH may submit recommendations to the DBPM regarding the merits or suggested resolution of any grievance/appeal.

xix. Handling Grievances and Appeals

- General Requirements - In handling grievances and appeals, the DBPM must meet the following requirements:

  - Acknowledge receipt of each grievance and appeal in writing;
  - 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;
  - Ensure that the individuals who make decisions on grievances and appeals are individuals:
    - Who were not involved in any previous level of review or decision-making; and
    - Who, if deciding any of the following, are healthcare professionals who have the appropriate clinical expertise, as determined by LDH, in treating the member's condition or disease:
      - An appeal of a denial that is based on lack of medical necessity; or
      - A grievance or appeal regarding denial of expedited resolution of an appeal; or
      - A grievance or appeal that involves clinical issues.

- Special Requirements for Appeals

  The process for appeals must:

  - Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal), and must be confirmed in writing unless the member or the provider requests expedited resolution. The member, 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 member follow-up is required.
  - Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well

as in writing. (The DBPM must inform the member of the limited time available for this in the case of expedited resolution).
  - Provide the member and his or her representative the opportunity, before and during the appeals process, to examine the member's case file, including dental records, and any other documents and records considered during the appeals process.
  - Include, as parties to the appeal:
    - The member and his or her representative; or
    - The legal representative of a deceased member's estate.

- Once an oral appeal is received:

  - The DBPM shall notify the enrollee verbally that a written confirmation is required for the appeal process to continue. The DBPM should inform the enrollee they will be receiving a notice for written confirmation of the appeal.
  - The DBPM will send a notice to the enrollee, acknowledging the oral appeal request was received and written confirmation is required. This notice must contain the timeframe for receipt of the written confirmation and future actions.
  - The DBPM will provide a form for the enrollee to sign and send back, as well as the options available for receipt of written confirmation (fax, email, regular postal mail).
  - The enrollee has fifteen (15) days from the date of the notice to send their written confirmation.
  - If written confirmation is not received within the fifteen (15) day timeframe:
    - The DBPM will close the appeal as incomplete for non-receipt of written confirmation.
    - The DBPM will send a notification to the enrollee of the appeal closure. This notice must consist of the reason for the incomplete appeal and inform the enrollee that they may submit a new appeal if they are within the original sixty (60) days of the adverse action. This closure does not escalate the appeal to a State Fair Hearing since the initial appeal process was not been completed.
- Once a request for an oral appeal has been closed for non-receipt of a written confirmation, a new appeal date can be established with an oral or written appeal request if it is within the original sixty (60) days of the adverse action.

- Training of DBPM Staff
  The DBPM's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.

- Identification of Appropriate Party
  The appropriate individual or body within the DBPM having decision making authority as part of the grievance/appeal procedure shall be identified.

- Failure to Make a Timely Decision
  Appeals shall be resolved no later than stated time frames and all parties shall be informed of the DBPM’s decision. If a

determination is not made in accordance with the timeframes specified in this contract, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

- Right to State Fair Hearing
  The DBPM shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the DBPM's decision in response to an appeal and the process for doing so.

xx. Notice of Action

- Language and Format Requirements
  The notice must be in writing and must meet the language and format requirements of 42 C.F.R. §438.10(c) and (d) to ensure ease of understanding.

- Content of Notice of Action
  The Notice of Action must explain the following:
  - The action the DBPM or its contractor has taken or intends to take;
  - The reasons for the action;
  - The member's or the provider's right to file an appeal with the DBPM;
  - The member's right to request a State Fair Hearing, after the DBPM's appeal process has been exhausted;
  - The procedures for exercising the rights specified in this section;
  - The circumstances under which expedited resolution is available and how to request it;
  - 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
  - Oral interpretation is available for all languages and how to access it.

- Timing of Notice of Action

  The DBPM must mail the Notice of Action within the following timeframes:

  - For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action, except when the period of advanced notice is shortened to five days if probable member fraud has been verified by the date of the action for the following:
    - In the death of a member,
    - A signed member 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 member's admission to an institution where he is ineligible for further services,
    - The member's address is unknown and mail directed to him has no forwarding address,
    - The member has been accepted for Medicaid services by another local jurisdiction, or

- The member's dentist prescribes the change in the level of dental care as permitted under 42 C.F.R. §431.213 and §431.214.

- For denial of payment, at the time of any action affecting the claim.
- 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:

  - The member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or
  - The DBPM justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.

- If the DBPM extends the timeframe in accordance, 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.

- On the date the timeframe for service authorization expires. Untimely service authorizations constitute a denial and are thus adverse actions.
- For expedited service authorization decisions where a provider indicates, or the DBPM 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 DBPM 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.
- The DBPM 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 DBPM justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.
- LDH shall conduct random reviews to ensure that members are receiving such notices in a timely manner.

xxi. Resolution and Notification

The DBPM 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 below.

- Specific Timeframes

  - 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 DBPM receives the grievance.

This timeframe may be extended under the terms of the contract below.

- 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 DBPM receives the appeal.
- 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 DBPM receives the appeal.

- Extension of Timeframes
  - The DBPM may extend the timeframes of this section by up to fourteen (14) calendar days if:
    - The member requests the extension; or
    - The DBPM shows (to the satisfaction of LDH, upon its request) that there is need for additional information and how the delay is in the member's interest.
  - Requirements Following Timeframe Extension
    If the DBPM extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.

- Format of Notice of Disposition
  - Grievances
    The DBPM will provide written notice to the member of the disposition of a grievance.
  - Appeals
    For all appeals, the DBPM must provide written notice of disposition.
  - Expedited Resolution
    For notice of an expedited resolution, the DBPM must also make reasonable efforts to provide oral notice.

- Content of Notice of Appeal Resolution
  The written notice of the resolution must include the following:
  - The results of the resolution process and the date it was completed; and
  - 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 DBPM's action.
- Requirements for State Fair Hearings
  LDH shall comply with the requirements of 42 CFR §431.200(b), §431.220(5), §438.414, and §438.10(g)(1). The DBPM shall comply with all requirements as outlined in this contract.
  - **Availability**
    If the member has exhausted the DBPM level appeal procedures, the member may request a State Fair

Hearing within thirty (30) days from the date of the DBPM's notice of resolution.

- **Parties**
  The parties to the State Fair Hearing include the DBPM as well as the member and his or her representative or the representative of a deceased member's estate.

xxii. Expedited Resolution of Appeals

The DBPM must establish and maintain an expedited review process for appeals, when the DBPM 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.

- Prohibition Against Punitive Action
  The DBPM must ensure that punitive action is not taken against a provider, acting on behalf of the member and with the member's written consent, that requests an expedited resolution or supports a member's appeal.
- Action Following Denial of a Request for Expedited Resolution
  - If the DBPM denies a request for expedited resolution of an appeal, it must:
    - Transfer the appeal to the timeframe for standard resolution in accordance with the prescribed timeframes; and
    - 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.
  - 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.
  - Failure to Make a Timely Decision
    Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the DBPM'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.
  - Process
    - The DBPM shall be 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. Appeals filed orally must be followed up in writing. No additional follow-up may be required.
    - The DBPM 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.
  - 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
- Format of Resolution Notice
  In addition to written notice, the DBPM must also make reasonable effort to provide oral notice.

xxiii. Continuation of Benefits

- Terminology - As used in this section, “timely'' filing means filing on or before the later of the following:
  - Within ten (10) calendar days of the DBPM mailing the notice of action; or
  - The intended effective date of the DBPM's proposed action.

- The DBPM must continue the member's benefits if:
  - The member or the provider, acting on behalf of the member and with the member's written consent, files the appeal timely;
  - The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
  - The services were ordered by an authorized provider;
  - The original period covered by the original authorization has not expired; and
  - The member requests extension of benefits.

- Duration of Continued or Reinstated Benefits
  If, at the member's request, the DBPM continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs:
  - The member withdraws the appeal;
  - Ten (10) calendar days pass after the DBPM 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;
  - A State Fair Hearing Officer issues a hearing decision adverse to the member; or
  - The time period or service limits of a previously authorized service has been met.

- 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 DBPM's action, the DBPM 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).

- Information to Providers and Contractors
  The DBPM must provide the information specified in federal regulations about the grievance system to all providers and contractors at the time they enter into a contract.

- Recordkeeping and Reporting Requirements
  Reports of grievances and resolutions shall be submitted to LDH as specified in this contract. The DBPM shall not modify the grievance procedure without the prior written approval of LDH.

- Services Not Furnished While the Appeal is Pending
  If the DBPM 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 DBPM must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires.

- Services Furnished While the Appeal is Pending
  If the DBPM 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 DBPM must pay for those services, in accordance with this Contract.

k) Quality Management

i. Quality Assessment and Performance Improvement Program (QAPI)

- The DBPM shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program, as described in 42 CFR 438.330(a)1; (a)2, to:
  - Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities;
  - Incorporate improvement strategies that include, but are not limited to:
    - performance improvement projects;
    - dental record audits;
    - performance measures; and
    - provider and member surveys
  - Detect underutilization and overutilization of services
  - Assess the quality and appropriateness of dental care furnished to enrollees with special healthcare needs.
- 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.
- 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.
- The DBPM shall submit its QAPI Program description to LDH for written approval.
- The DBPM's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the DBPM'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 DBPM.

ii. QAPI Committee

- The DBPM shall form a QAPI Committee that shall, at a minimum include:
  - The DBPM Dental Director must serve as either the chairman or co-chairman;

- Appropriate DBPM staff representing the various departments of the organization will have membership on the committee; and
- The DBPM is encouraged to include a member advocate representative on the QAPI Committee.

- QAPI Committee Responsibilities

  The committee shall:
  - Meet on a quarterly basis;
  - Direct and review quality improvement (QI) activities;
  - Ensure that QAPI activities are implemented throughout the DBPM;
  - Review and suggest new and or improved QI activities;
  - Direct task forces/committees to review areas of concern in the provision of healthcare services to members;
  - Designate evaluation and study design procedures;
  - Conduct individual primary care dentist and primary care dentist practice quality performance measure profiling;
  - Report findings to appropriate executive authority, staff, and departments within the DBPM;
  - Direct and analyze periodic reviews of members' service utilization patterns;
  - Maintain minutes of all committee and sub-committee meetings and submit a summary of the meeting minutes to LDH with other quarterly reports;
  - Report an evaluation of the impact and effectiveness of the QAPI program to LDH annually. This report shall include, but is not limited to, all care management activities; and
  - Ensure that a QAPI committee designee attends LDH Quality Committee meetings.

- 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 LDH annually and prior to revisions. The QAPI plan, at a minimum, shall:

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

- QAPI Reporting Requirements

  - The DBPM shall submit QAPI reports annually to LDH which, at a minimum, shall include:
    - Quality improvement (QI) activities;
    - Recommended new and/or improved QI activities; and

        - Evaluation of the impact and effectiveness of the QAPI program.
    - LDH reserves the right to request additional reports as deemed necessary. LDH will notify the DBPM of additional required reports no less than sixty (60) days prior to due date of those reports.

l) Performance Measures

i. The DBPM shall report clinical and administrative performance measure (PM) data on at least an annual basis, as specified by LDH.

- The DBPM shall report on PMs listed in Attachment D which include, but are not limited to, Agency for Healthcare Research and Quality Review (AHRQ), Dental Quality Alliance (DQA), and/or other measures as determined by LDH.
- The DBPM shall have processes in place to monitor and report all performance measures.
- Clinical PM outcomes shall be submitted to LDH at least annually and upon LDH request. Detailed data shall be made available to support any summary report of Clinical outcomes QIPIs.
- Administrative PMs shall be submitted to LDH at least quarterly and upon LDH request. Detailed data shall be made available to support any summary report of Administrative QIPIs.
- The reports and data shall demonstrate adherence to clinical practice guidelines and shall demonstrate changes in patient outcomes.
- Performance measures may be used to create Performance Improvement Plans which are the DBPM's activities to design, implement and sustain systematic improvements based on their own data.

ii. Performance Measures Reporting

- All Administrative PMs are reporting measures.
    - Administrative measure reporting is required at least quarterly and upon LDH's request.
    - Clinical Performance measures shall be reported at least annually and upon LDH request 12 months after services begin.
- LDH may add or remove PM reporting requirements with a sixty (60) day advance notice.

iii. Performance Measurement Goals

- The Department shall establish benchmarks for Performance Measures utilizing statewide data of the Medicaid Fee for Service population from 2013 with the expectation that performance improves by a certain percentage toward the benchmarks.
- The Performance Measurement Goals are listed in Attachment D.
- At the department's discretion after the initial contract year, a maximum of 1% (0.5% for each of the 2 clinical performance measures) of the total monthly capitation payment may be deducted from the total capitation payment to be made in the month of May following the measurement if clinical performance measures fall below LDH's established benchmarks for improvement.

iv. Performance Indicator Reporting Systems

- The DBPM shall utilize LDH-approved systems, operations, and performance monitoring tools and/or automated methods for monitoring. Access to such systems and tools shall be granted to LDH as needed for oversight.
- The monitoring tools and reports shall be flexible and adaptable to changes in the quality measurements required by LDH.
- The DBPM shall have processes in place to monitor and self-report performance measures included by not limited to measures listed in Attachment D.
- The DBPM shall provide individual primary care dentist clinical quality profile reports.

v. Performance Measure Monitoring

- LDH will monitor the DBPM's performance using Benchmark Performance and Improvement Performance data.
- During the course of the Contract, LDH or its designee shall communicate with the DBPM regarding the data and reports received as well as meet with representatives of the DBPM to review the results of performance measures.
- The DBPM shall comply with External Quality Review, review of the Quality Assessment Committee meeting minutes and annual dental audits to ensure that it provides quality and accessible healthcare to DBPM members, in accordance with standards contained in the Contract. Such audits shall allow LDH or its duly authorized representative to review individual dental 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.
- The standards by which the DBPM shall be surveyed and evaluated will be at the sole discretion and approval of LDH. If deficiencies are identified, the DBPM must formulate a Corrective Action Plan (CAP) incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. LDH must prior approve the CAP and will monitor the DBPM's progress in correcting the deficiencies.

vi. Performance Measure Corrective Action Plan

- A corrective action plan (CAP) shall be required for performance measures that do not reach the Department's performance benchmark.
- The DBPM shall submit a CAP within thirty (30) calendar days of the date of notification or as specified by LDH, for the deficiencies identified by LDH.
- Within thirty (30) calendar days of receiving the CAP, LDH will either approve or disapprove the CAP. If disapproved, the DBPM shall resubmit, within fourteen (14) calendar days, a new CAP that addresses the deficiencies identified by LDH.
- Upon approval of the CAP, whether the initial CAP or the revised CAP, the DBPM shall implement the CAP within the time frames specified by LDH.
- LDH may impose monetary penalties, and sanctions pending attainment of acceptable quality of care.

m) Annual Member Satisfaction Survey

i. The DBPM shall conduct annual LDH-approved member satisfaction surveys comparable to the Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members each contract year.
ii. Survey results and a description of the survey process shall be reported to LDH.
iii. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the DBPM at the time of the survey.
iv. The surveys shall provide valid and reliable data for results statewide.
v. Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.
vi. Member Satisfaction Survey Reports are due 120 calendar days after the end of the contract year.

n) Provider Satisfaction Surveys

i. The DBPM shall conduct an annual provider survey to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, and utilization management processes. The Provider Satisfaction survey tool and methodology must be submitted to LDH for approval prior to administration.
ii. The DBPM shall submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due 120 days after the end of the plan year.

o) LDH Oversight of Quality

i. LDH shall evaluate the DBPM's QAPI, PMs, and Performance Improvement Plans at least one (1) time per year at dates to be determined by LDH, or as otherwise specified by the Contract.
ii. If LDH determines that the DBPM's quality performance is not acceptable, the DBPM must submit a corrective action plan (CAP) for each unacceptable performance measure. If the DBPM fails to provide a CAP within the time specified, LDH will sanction the DBPM in accordance with the provisions of sanctions set forth in the Contract.
iii. Upon any indication that the DBPM's quality performance is not acceptable, LDH may impose sanctions or terminate the contract.
iv. The DBPM shall cooperate with LDH, the independent evaluation contractor (External Quality Review Organization), and any other Department designees during monitoring.

p) Credentialing and Re-credentialing of Providers and Clinical Staff

i. The DBPM must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, and §438.230 for the review and credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the DBPM selects and directs it members to see a specific provider or group of providers. These procedures shall be submitted as part of the Proposal, when a change is made, and annually thereafter.
ii. The DBPM shall completely process credentialing applications from all types of provider types within sixty (60) calendar days of receipt

of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. "Completely process" shall mean that the DBPM 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 LDH or LDH's designee; or
- Deny the application and ensure that the provider is not used by the DBPM.

iii. The process for periodic re-credentialing shall be implemented at least once every thirty-six (36) months.

iv. If the DBPM has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the contract. The DBPM must require that the subcontractor provide assurance that all licensed dental professionals are credentialed in accordance with LDH's credentialing requirements. LDH will have final approval of the delegated entity.

v. The DBPM shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to ensure compliance with the Contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.

vi. The DBPM shall develop and implement a mechanism, with LDH's approval, for reporting quality deficiencies which result in suspension or termination of a network provider/ subcontractor(s). This process shall be submitted for review and approval at the time of any change.

vii. The DBPM shall develop and implement a provider dispute and appeal process, with LDH's approval, for sanctions, suspensions, and terminations imposed by the DBPM against network provider/contractor(s) as specified in the Contract.

viii. This process shall be submitted for review and approval at the time of any change.

12. Medical Loss Ratio
    a) In accordance with the DBPM Financial Reporting Guide published by LDH, the DBPM shall provide an annual Medical Loss Ratio (MLR) report following the end of the MLR reporting year, which shall be a calendar year.
    b) An MLR shall be reported in the aggregate, including all dental services covered under the contract.
    c) If the aggregate MLR (cost for dental benefits and services and specified quality expenditures) is less than eighty-five percent (85%), the DBPM shall refund LDH the difference. Any unpaid balances after the refund is due shall be subject to interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher.
    d) Neither the minimum MLR standard (85%) nor the refund applicable to the aggregate MLR shall apply to distinct MLRs reported.

13. Health Insurance Provider Fee (HIPF) Reimbursement
    If the DBPM 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 DBP's net premiums written from LDH's Medicaid/CHIP lines of business, LDH shall, upon the DBPM satisfying completion of the requirements below, make an annual payment to the DBPM in each calendar year payment is due to the IRS (the "Fee Year"). This annual payment will be calculated by LDH (and its contracted actuary) as an adjustment to the

DBPM's capitation rates, in accordance with the DBP Financial Reporting Guide, for the full amount of the Annual Fee allocable to Louisiana Medicaid/CHIP with respect to premiums paid to the DBP for the preceding calendar year (the "Data Year.") The adjustment will be to the capitation rates in effect during the Data Year.

a) The DBPM shall, at a minimum, be responsible for adhering to the following criteria and reporting requirements:
   i. Provide LDH with a copy of the final Form 8963 submitted to the IRS by the deadline to be identified in the table at the end of this section. The DBPM shall provide LDH with any adjusted Form 8963 filings to the IRS within five (5) business days of any amended filing.
   ii. Provide LDH Louisiana-specific Medicaid and CHIP-specific premiums included in the premiums reported on Form 8963 (including any adjusted filings) by the deadline to be identified by LDH each year, (for the initial Form 8963 filing) of the Fee Year and within 5 business days of any amended filing.
   iii. If the DBPM'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 DBPM's Form 8963 and a methodological description of how its Louisiana-specific Medicaid/CHIP premium revenue (payments to the DBPM pursuant to this Contract) was determined. The DBPM will indicate for LDH the portion of the Louisiana-specific Medicaid/CHIP premiums that were excluded from the Form 8963 premiums by the DBP as Medicaid long-term care, if applicable, beginning with Data Year 2014.
      - The DBPM shall also submit a certification regarding the supplemental delineation consistent with 42 CFR §438.604 and 42 CFR 438.606.
      - If a portion of the Louisiana-specific Medicaid/CHIP premiums were excluded from the Form 8963 premiums by the DBPM as Medicaid long-term care, the DBPM shall submit the calculations and methodology for the amount excluded.
   iv. Provide LDH with the preliminary calculation of the Annual Fee as determined by the IRS by the deadline identified by LDH each year.
   v. Provide LDH with the final calculation of the Annual Fee as determined by the IRS by the deadline identified by LDH each year .
   vi. Provide LDH with the applicable federal and state income tax rates – federal and state (if applicable) -- by the deadlines identified by LDH each year and include a certification regarding such income tax rates consistent with 42 CFR §438.604 and §438.606.
b) For covered entities subject to the HIPF, LDH calculates the HIPF percentage in accordance with the steps outlined in the DBP Financial Reporting Guide 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 to reasonably by LDH.
c) LDH (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 DBP.
d) In accordance with the schedule provided in the DBP Financial Reporting Guide, LDH will make a payment to the DBPM that is

based on the final Annual Fee amount provided by the IRS and calculated by LDH (and its contracted actuary) as an adjustment to the capitation rates in effect during the Data Year. This payment will only be made to the Contactor if LDH determines that that the reporting requirements under this section have been satisfied.

e) The DBPM shall advise LDH if payment of the final fee payment is less than the amount invoiced by the IRS.
f) The DBPM shall reimburse LDH for any amount applicable to Louisiana Medicaid/CHIP premiums that are not paid towards the fee and/or are reimbursed back to the DBPM, at any time and for any reason, by the IRS.
g) LDH reserves the right to update the calculation and method of payment for the Annual Fee based upon any new or revised requirements established by CMS in regards to this fee. In the event the calculation methodology or method of timing of payment for the Annual Fee as set forth in the DBP Financing Reporting Guide requires modification, LDH will obtain DBPM input regarding the required modification(s) prior to the implementation of the modification.
h) Payment by LDH is intended to put the DBPM in the same position as the DBPM would have been in had the DBPM'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 applicable tax rates been known in advance and used in the determination of the Data Year capitation rates.
i) This section shall survive the termination of the contract.

4. Staffing Requirements/Qualifications

A. The DBPM shall have in place the organizational, operational, managerial, and administrative systems capable of fulfilling all contract requirements. The DBPM shall be staffed by qualified persons in numbers appropriate to the DBPM's size of enrollment.
B. For the purposes of this contract, the DBPM 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), §1001.1901(b), and §1003.102(a)(2)]. The DBPM must screen all employees and sub-contractors to determine whether any of them have been excluded from participation in federal healthcare programs. The HHS-OIG website, which can be searched by the names of any individual, can be accessed at the following URL: http://www.oig.hhs.gov/fraud/exclusions.asp
C. The DBPM must employ sufficient staffing and utilize appropriate resources to achieve contractual compliance. The DBPM's resource allocation must be adequate to achieve outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with contractual and LDH policy requirements, including the requirement for providing culturally competent services. If the DBPM does not achieve the desired outcomes or maintain compliance with contractual obligations, additional monitoring and regulatory action may be employed by LDH, including but not limited to requiring the DBPM to hire additional staff and application of monetary penalties.
D. The DBPM shall comply with LDH Policy 47.1, "Criminal History Records Check of Applicants and Employees", which requires criminal background checks to be performed on all employees of LDH contractors who have access to electronic protected health information on Medicaid applicants and beneficiaries. It shall, upon request, provide LDH with a satisfactory criminal background check or an attestation that a satisfactory criminal background

check has been completed for any of its staff or subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this Contract.

E. Key Personnel Positions

1. An individual staff member shall not occupy more than one of the key personnel positions listed below unless prior approval is obtained by LDH or otherwise stated below.
2. The DBPM may terminate any of its employees designated to perform work or services under this Contract, as permitted by applicable law.
3. The DBPM shall inform LDH in writing when an employee vacates one of the director positions listed below (this requirement does not apply to additional required staff, also listed below). The name of the interim contact person shall be included with the notification. This notification shall take place within (5) business days of the resignation/termination.
4. The DBPM shall replace any of the key personnel with a person of equivalent experience, knowledge and talent, within thirty (30) calendar days of resignation/termination of previous staff. The name and resume of the permanent employee shall be submitted, within five (5) business days of the new hire taking place along with a revised organization chart complete with key personnel time allocation.
5. Replacement of the Executive Director or Dental Director shall require or prior written approval from LDH (*i.e.*, Medicaid Director or his/her designee) which shall not be unreasonably withheld provided a suitable candidate is proposed.
6. Annually, the DBPM must provide the name, Social Security Number and date of birth of the staff members performing the duties of the key personnel. LDH 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].
7. The DBPM must designate key management and technical personnel who will be assigned to the Contract. For the purposes of this requirement, Key Personnel are those with management responsibility or principal technical responsibility for the following functional areas:

   a) Member Services;
   b) Management Information Systems;
   c) Claims Processing;
   d) Provider Network Development and Management
   e) Benefit Administration and Utilization and Care Management;
   f) Quality Improvement;
   g) Financial Functions;
   h) Reporting;
   i) Executive Director; and
   j) Dental Director.

F. In-State Positions

The DBPM shall maintain a physical presence in Louisiana. Positions that shall be located in Louisiana are the following:

1. Executive Director
   a) The DBPM must employ a qualified individual to serve as the Executive Director for the Dental Program. Such Executive Director must be employed full-time by the DBPM, be primarily dedicated to the Dental Program, and must hold a Senior Executive or Management position in the DBPM's organization, except that the DBPM may propose an alternate structure for the Executive Director position, subject to LDH's prior review and written approval.

   b) The Executive Director must be authorized and empowered to represent the DBPM regarding all matters pertaining to the Contract prior to such representation. The Executive Director must act as liaison

between the DBPM and LDH and must have responsibilities that include, but are not limited to:

i. Ensuring the DBPM's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance.
ii. Receiving and responding to all inquiries and requests made by LDH related to the Contract, in the timeframes and formats specified by LDH. Where practicable, LDH will consult with the DPBM to establish timeframes and formats reasonably acceptable to the Parties.
iii. Attending and participating in regular meetings or conference calls with LDH.
iv. Making best efforts to promptly resolve any issues identified either by the DBPM or LDH that may arise and are related to the Contract.
v. Meeting with LDH representative(s) on a periodic or as needed basis to review the DBPM's performance and resolve issues.
vi. Meeting with LDH at the time and place requested by LDH, if LDH determines that the DBPM is not in compliance with the requirements of the Contract.

2. Dental Director - must have a qualified full-time individual to serve as the Dental Director for the DBPM.

a) The Dental Director must be currently licensed in Louisiana as a Doctor of Dentistry ("dentist") with no restrictions or other licensure limitations. The Dental Director must comply with applicable federal and state statutes and regulations.
b) The Dental Director must be available during normal business hours for Utilization Review decisions, and must be authorized and empowered to represent the DBPM regarding clinical issues, Utilization Review and quality of care inquiries.

3. Staff performing the Provider Network Development and Management function.

G. Written Policies, Procedures, and Job Description

1. The DBPM shall develop and maintain written policies, procedures and job descriptions for each functional area, consistent in format and style. The DBPM 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 DBPM's written policies reflect current practices. Reviewed policies shall be dated and signed by the DBPM's appropriate manager, coordinator, director or administrator. Minutes reflecting the review and approval of the policies by an appropriate committee are also acceptable documentation. All dental and quality management policies must be approved and signed by the DBPM's Dental Director. Job descriptions shall be reviewed at least annually to ensure that current duties performed by the employee reflect written requirements.
2. Based on provider or member feedback, if LDH deems a DBPM policy or process to be inefficient and/or places an unnecessary burden on the members or providers, the DBPM shall be required to work with LDH to change the policy or procedure within a time period specified by LDH.

H. Staff Training and Meeting Attendance

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

2. The DBPM must provide initial and ongoing staff training that includes an overview of LDH, Medicaid Policy and Procedure Manuals, and Contract and state and federal requirements specific to individual job functions. The DBPM 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.
3. New and existing prior authorization and member services representatives must be trained in the geography of Louisiana and have access to mapping search engines (*e.g.,* MapQuest, Yahoo Maps, Google Maps, etc.) for the purposes of authorizing services in; recommending providers in; and transporting members to the most geographically appropriate location.
4. The DBPM shall provide the appropriate staff representation for attendance and participation in meetings and/or events scheduled by LDH. All meetings shall be considered mandatory unless otherwise indicated.
5. LDH reserves the right to attend any and all training programs and seminars conducted by the DBPM. The DBPM shall provide LDH a list of any marketing training dates and time and location, at least fourteen (14) calendar days prior to the actual date of training.

I. Annual Reporting to LDH

The DBPM must submit to the LDH the following items annually:

1. An updated organization chart complete with the key personnel 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.
2. A functional organization chart of the key program areas, responsibilities and the areas that report to that position.
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.

5. Reporting Requirements

A. General Requirements

1. The DBPM shall comply with all the reporting requirements established by this Contract. As per 42 CFR §438.242(a), (b)(1), (2), and (3), the DBPM shall maintain a health information system that collects, analyzes, integrates and reports data that complies with LDH and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization and grievances and appeals. The DBPM shall collect data on member and provider characteristics and on services furnished to members.
2. The DBPM shall create reports or files (known as Deliverables) using the electronic formats, instructions, and timeframes as specified by LDH and at no cost to LDH. Any changes to the formats must be approved by LDH prior to implementation.
3. In the event that there are no instances to report, the DBPM shall submit a report so stating.
4. As required by 42 CFR §438.604(a) and (b), and 42 CFR §438.606, the DBPM shall certify all submitted data, documents and reports. The data that must be certified include, but are not limited to, financial reports, encounter data, and other information as specified within this contract. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The DBPM must submit the certification concurrently with the certified data and documents. LDH will identify specific data that requires certification.
5. The data shall be certified by one of the following:
   a) The DBPM's Executive Director; or

b) An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

6. The DBPM shall comply with all court-ordered reporting requirements currently including but not limited to the *Wells v. Gee* and *Chisholm v. Gee* cases in the manner determined by LDH.

B. Ad Hoc Reports

The DBPM shall prepare and submit any other reports as required and requested by LDH, any of LDH designees, and/or CMS, that is related to the DBPM's duties and obligations under this Contract. Information considered to be of a proprietary nature shall be clearly identified as such by the DBPM at the time of submission. LDH will make every effort to provide a sixty (60) day notice of the need for submission to give the DBPM adequate time to prepare the reports. However, there may be occasions the DBPM will be required to produce reports in a shorter timeframe.

C. Ownership Disclosure

Federal laws require full disclosure of ownership, management, and control of Medicaid Managed Care Entities (42 CFR §§455.100-455.106). The Medicaid Ownership and Disclosure Form, is to be submitted to LDH prior to implementation for each Contract period or when any change in the DBPM's management, ownership or control occurs. The DBPM shall report any changes in ownership and disclosure information to LDH within thirty (30) calendar days prior to the effective date of the change.

D. Information Related to Business Transactions

1. The DBPM shall furnish to LDH 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.
2. The DBPM shall submit, within thirty-five (35) days of a request made by LDH, full and complete information about:
   a) The ownership of any subcontractor with whom the DBPM has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of this request; and
   b) Any significant business transactions between the DBPM and any wholly owned supplier or between the DBPM and any subcontractor, during the five (5) year period ending on the date of this request.
3. For the purpose of this Contract, "significant business transactions" means any business transaction or series of transactions during any state fiscal year that exceed the $25,000 or five (5) percent of the DBPM's total operating expenses whichever is greater.
4. Report of Transactions with Parties in Interest
   a) The DBPM shall report to LDH all "transactions" with a "party in interest" as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B), as required by Section 1903(m)(4)(A) of the Social Security Act. Federally qualified plans are exempt from this requirement.
      i. Definition of Party in Interest – As defined in 1318(b) of the Public Health Service Act, a party in interest is:
         - (1) any director, officer, partner, or employee responsible for management or administration of a health maintenance organization, any person who is directly or indirectly the beneficial owner of more than 5 per centum of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 per centum of the health maintenance organization, and, in the case of a health maintenance organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

- (2) any entity in which a person described in paragraph (1)—

(A) is an officer or director;
(B) is a partner (if such entity is organized as a partnership);
(C) has directly or indirectly a beneficial interest of more than 5 per centum of the equity; or
(D) has a mortgage, deed of trust, note, or other interest valuing more than 5 per centum of the assets of such entity;

- (3) any person directly or indirectly controlling, controlled by, or under common control with a health maintenance organization; and

(4) any spouse, child, or parent of an individual described in paragraph (1).

ii. Types of Transactions Which Must Be Disclosed – Business transactions which must be disclosed include:
- Any sale, exchange, or lease of any property between the DBPM and a party in interest;
- Any lending of money or other extension of credit between the DBPM and the party in interest; and
- Any furnishing for consideration of goods, services (including management services), or facilities between the DBPM and the party in interest. This does not include salaries paid to employees for services in the normal course of their employment.

iii. The information that must be disclosed in the transactions listed in section above between a DBPM and a party in interest includes
- The name of the party in interest for each transaction;
- A description of each transaction and the quantity or units involved;
- The accrued dollar value of each transaction during the fiscal year; and
- Justification of the reasonableness of each transaction.

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

v. If the DBPM 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. The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the DBPM's business transactions must be reported.

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

E. Encounter Data

1. The DBPM shall comply with the required format provided by LDH. Encounter data includes claims paid by the DBPM for services delivered to members through the DBPM during a specified reporting period. LDH collects and uses this data for many reasons such as: federal reporting, rate setting, service verification, managed care quality improvement program, utilization patterns, access to care, and research studies.
2. LDH may change the Encounter Data Transaction requirements with thirty (30) calendar days' written notice to the DBPM. The DBPM shall, upon notice from LDH, provide notice of changes to subcontractors.

F. Information on Persons Convicted of Crimes

The DBPM shall furnish LDH 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.

G. Errors

1. The DBPM agrees to prepare complete and accurate reports for submission to LDH. If after preparation and submission, a DBPM error is discovered either by the DBPM or LDH; the DBPM shall correct the error(s) and submit accurate reports as follows:
   a) For encounters - In accordance with the timeframes specified in the Administrative Actions, Monetary Penalties and Sanctions Section of this contract.
   b) For all reports – Fifteen (15) calendar days from the date of discovery by the DBPM or date of written notification by LDH (whichever is earlier). LDH may at its discretion extend the due date if an acceptable corrective action plan has been submitted and the DBPM can demonstrate to LDH's satisfaction the problem cannot be corrected within fifteen (15) calendar days.
2. Failure of the DBPM to respond within the above specified timeframes may result in a loss of any money due the DBPM and the assessment of monetary penalties as provided in Administration Actions, Monetary Penalties and Sanctions Section of this contract.

H. Report Submission Timeframes

1. The DBPM shall ensure that all required reports or files, as stated in this contract, are submitted to LDH in a timely manner for review and approval. The DBPM's failure to submit the reports or files as specified may result in the assessment of monetary penalties, as stated in the Administrative Actions, Monetary Penalties, and Sanctions Section of this contract.
2. Unless otherwise specified, deadlines for submitting files and reports are as follows:
   a) Daily reports and files shall be submitted within one (1) business day following the due date;
   b) Weekly reports and files shall be submitted on the Wednesday following the reporting week;
   c) Monthly reports and files shall be submitted within fifteen (15) calendar days of the end of each month;
   d) Quarterly reports and files shall be submitted by April 30, July 31, October 31, and January 31, for the quarter immediately preceding the due date;
   e) Annual reports and files shall be submitted on January 31 for the prior calendar year; and
   f) Ad Hoc reports shall be submitted within three (3) business days from the agreed upon date of delivery.

I. Report Submissions

The DBPM should submit reports as directed by LDH and in the format provided by LDH or outlined on www.makingmedicaidbetter.com.

J. Transition/Turnover Plan

1. Introduction

   Turnover is defined as those activities that the DBPM is required to perform upon termination of the Contract in situations in which the DBPM must transition contract operations to LDH or a third party. The turnover requirements in this Section are applicable upon any termination of the Contract.

2. General Turnover Requirements

   In the event the Contract is terminated for any reason, the DBPM shall:

a) Comply with all terms and conditions stipulated in the Contract, including continuation of core dental benefits and services under the Contract, until the termination effective date;
b) Promptly supply all information necessary for the reimbursement of any outstanding claims; and
c) Comply with direction provided by LDH to assist in the orderly transition of equipment, services, software, leases, etc. to LDH or a third party designated by LDH.

3. Turnover Plan
   a) In the event of written notification of termination of the Contract by either party, the DBPM shall submit a Turnover Plan within thirty (30) calendar days from the date of notification, or circumstances necessitate a shorter timeframe, unless other appropriate timeframes have been mutually agreed upon by both the DBPM and LDH. The Plan shall address the turnover of records and information maintained by the DBPM relative to core dental benefits and services provided to Medicaid members for the time form specified by LDH. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by LDH.
   b) If the Contract is not terminated by written notification as provided in 22.3.1 above, the DBPM 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 LDH or a third party designated by LDH. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by LDH.
   c) As part of the Turnover Plan, the DBPM must provide LDH with copies of all relevant member and core dental benefits and services data, documentation, or other pertinent information necessary, as determined by LDH, for LDH or a subsequent DBPM to assume the operational activities successfully. This includes correspondence, documentation of ongoing outstanding issues, and other operations support documentation. The Plan will describe the DBPM's approach and schedule for transfer of all data and operational support information, as applicable. The information must be supplied in media and format specified by LDH and according to the schedule approved by LDH.

4. Transfer of Data
   a) The DBPM shall transfer all data regarding the provision of member core dental benefits and services to LDH or a third party, at the sole discretion of LDH and as directed by LDH. All transferred data must be compliant with HIPAA.
   b) All relevant data must be received and verified by LDH or the subsequent DBPM. If LDH determines that not all of the data regarding the provision of member core dental benefits and services to members was transferred to LDH or the subsequent DBPM, as required, or the data is not HIPAA compliant, LDH reserves the right to hire an independent contractor to assist LDH in obtaining and transferring all the required data and to ensure that all the data are HIPAA compliant. The reasonable cost of providing these services will be the responsibility of the DBPM.

5. Post-Turnover Services
   a) Thirty (30) days following turnover of operations, the DBPM must provide LDH with a Turnover Results report documenting the completion and results of each step of the Turnover Plan. Turnover will not be considered complete until this document is approved by LDH.
   b) If the DBPM does not provide the required relevant data and reference tables, documentation, or other pertinent information necessary for LDH

or the subsequent DBPM to assume the operational activities successfully, the DBPM agrees to reimburse LDH for all reasonable costs, including, but not limited to, transportation, lodging, and subsistence for all state and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, reproduction and transfer functions at the location(s) of such records.

c) The DBPM also must pay any and all additional costs incurred by LDH that are the result of the DBPM's failure to provide the requested records, data or documentation within the time frames agreed to in the Turnover Plan.

d) The DBPM must maintain all files and records related to members and providers for five 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 DBPM agrees to repay any valid, undisputed audit exceptions taken by LDH in any audit of the Contract.

C. Fraud and Abuse

1. General Requirements

A. The DBPM 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, La. R.S. 46:437.1-437.14, and LAC 50.I.4101-4235.

B. The DBPM shall meet with LDH and the Attorney General's Medicaid Fraud Control Unit (MFCU), periodically, at LDH's request, to discuss fraud, abuse, neglect and overpayment issues. For purposes of this Section, the DBPM's compliance officer shall be the point of contact for the DBPM.

C. The DBPM shall cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, the United States Department of Health and Human Services (HHS), the United States and/or Louisiana's Legislative Auditor's Office, the United States and/or Louisiana's Office of the Attorney General, the United States Government Accountability Office (GAO), Comptroller General of the United States, LDH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of ten 10 years from the completion of an audit or the expiration date of the Contract (including any extensions to the Contract), whichever is later, shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the Contract and any other applicable rules.

D. The DBPM and its subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above. Each federal and state agency shall have timely and unrestricted access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with DBPM clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The DBPM shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

E. The DBPM'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.

F. The DBPM and its subcontractors shall provide access to LDH and/or its designee to all information related to grievances and appeals filed by its members. LDH shall monitor enrollment and termination practices and ensure proper implementation

of the DBPM's grievance procedures, in compliance with 42 CFR §§438.226-438.228.

G. The DBPM shall certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The DBPM shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, the Contract, and LDH policy.

H. The DBPM shall report to LDH, within three (3) business days, when it is discovered that any DBPM employees, network provider, contractor, or contractor's employees have been excluded, suspended, or debarred from any state or federal healthcare benefit program through the following url: http://new.dhh.louisiana.gov/index.cfm/page/219 or LDH prior approved method.

I. The DBPM 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 DBPM shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities.

J. The DBPM, as well as its subcontractors and providers, whether contract or non-contact, 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.

K. The DBPM, 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 DBPM dependent upon the entity that identifies the payment of unallowable funds to excluded individuals

L. The DBPM 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:
    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
    2. The improperly paid funds have already been recovered by the State's Recovery Audit Contractor (RAC) contractor; or
    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.

M. <u>This prohibition described above shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. In the event that the DBPM obtains funds in cases where recovery recoupment or withhold is prohibited under this Section, the DBPM will return the funds to LDH.</u>

N. The DBPM 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.

O. Reporting and Investigating Suspected Fraud and Abuse
    1. The DBPM shall cooperate with all appropriate state and federal agencies, including MFCU, in investigating fraud and abuse.

2. The DBPM shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §455.13, §455.14, and §455.21), both internally and for its subcontractors.
3. The DBPM shall notify MFCU and LDH 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 DBPM shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to MFCU and LDH when the concerns and/or allegations of any tips are authenticated.
4. The DBPM shall report all tips, confirmed or suspected fraud, waste and abuse to LDH and the appropriate agency as follows:
    a) All tips (any program integrity case opened within the previous two (2) weeks) shall be reported to LDH and MFCU;
    b) Suspected fraud and abuse in the administration of the program shall be reported to LDH and MFCU;
    c) All confirmed or suspected provider fraud and abuse shall immediately be reported to LDH and MFCU; and
    d) All confirmed or suspected enrollee fraud and abuse shall be reported immediately to LDH and local law enforcement.
5. The DBPM shall utilize a Fraud Reporting Form deem satisfactory by the agency to whom the report is to be made under the terms of this Contract.
6. The DBPM shall be subject to a civil penalty, to be imposed by LDH, for willful failure to report fraud and abuse by beneficiaries, enrollees, applicants, or providers to LDH MFCU, as appropriate.
7. The DBPM shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the DBPM shall not take any of the following actions as they specifically relate to Medicaid claims:
    a) Contact the subject of investigation about any matters related to the investigation;
    b) Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
    c) Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
8. The DBPM shall promptly provide the results of its preliminary investigation to LDH or the agency to whom the incident was reported, or t another agency designated by the agency that receive the report.
9. The DBPM 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 DBPM employees and consultants, including but not limited to those with expertise in the administration of the program and/or dental questions or in any matter related to an investigation.

P. The State shall not transfer its law enforcement functions to the DPBM.
Q. The DBPM and its subcontractors 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 dental 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.

R. The DBPM and/or its subcontractors shall include in all of their provider agreements a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with this Section C.1.
S. The DBPM shall notify LDH when the DBPM denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.
T. Except as described in this section, nothing herein shall require the DBPM to ensure that non-contract providers are compliant with Louisiana Medicaid contracts or state and/or federal law.
U. In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, the DBPM shall report overpayments made by LDH to the DBPM as well as overpayments made by the DBPM to a provider and/or subcontractor.

2. Fraud and Abuse Compliance Plan

A. In accordance with 42 CFR §438.608(a), the DBPM shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.
B. In accordance with 42 CFR §438.608(b)(2), the DBPM shall designate a compliance officer and compliance committee that have the responsibility and authority for carrying out the provisions of the compliance program. These individuals shall be accountable to the DBPM's board of directors and shall be directly answerable to the Executive Director or to the board of directors and senior management. The DBPM shall have an adequately staffed Medicaid compliance office with oversight by the compliance officer.
C. The DBPM shall submit the Fraud and Abuse Compliance Plan within thirty (30) calendar days from the date the Contract is signed with the DBPM. The DBPM shall submit updates or modifications to LDH for approval at least thirty (30) calendar days in advance of making them effective. LDH, at its sole discretion, may require that the DBPM modify its compliance plan. The DBPM compliance program shall incorporate the following policies and procedures:
    1. written policies, procedures, and standards of conduct that articulate DBPM's commitment to comply with all applicable federal and state standards;
    2. effective lines of communication between the compliance officer and the DBPM's employees, providers and contractors enforced through well-publicized disciplinary guidelines;
    3. procedures for ongoing monitoring and auditing of DBPM systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous quality improvement activities, and provider activities;
    4. provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the compliance officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;
    5. provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR §438.608(b)(4-6);
    6. protections to ensure that no individual who reports compliance plan violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the DBPM. The DBPM shall ensure that the identity of individuals reporting violations of the compliance plan shall be held in confidence to the utmost extent possible. Anyone who believes that he or she has been retaliated against may report this violation to the Louisiana Medicaid Office of Program Integrity and/or the U.S. Office of Inspector General;

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);
8. well-publicized disciplinary procedures that shall apply to employees who violate the DBPM's compliance program;
9. effective training and education for the compliance officer, managers, employees, providers and members to ensure that they know and understand the provisions of DBPM's compliance plan;
10. fraud, waste and abuse training shall include, but not be limited to:
    a. Annual training of all employees; and
    b. New hire training within thirty (30) days of beginning date of employment;
11. procedures for timely consistent exchange of information and collaboration with the LDH Program Integrity Unit;
12. 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; and
13. requirements for 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:
    a. DBPM Code of Conduct Training;
    b. Privacy and Security – Health Insurance Portability and Accountability Act;
    c. Fraud, waste and abuse;
    d. Procedures for timely consistent exchange of information and collaboration with LDH; and
    e. 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.

3. Prohibited Affiliations

A. In accordance with 42 CFR §438.610, the DBPM is prohibited from knowingly having a relationship of the type specified in paragraph B below 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. The DBPM shall comply with all applicable provisions of 42 CFR Part 376 pertaining to debarment and suspension. The DBPM shall screen all employees and contractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, or any other federal healthcare programs. To help make this determination, the DBPM shall search the following websites to comply with requirements set forth at 42 CFR §455.436:
   - Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
   - Healthcare Integrity and Protection Data Bank (HIPDB) *The Data Banks*
   - Louisiana Exclusion Database (LED);
   - The System of Award Management (SAM); and
   - Other applicable sites as may be determined by LDH.

   The DBPM 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 LDH within three (3) business days. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This 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).

B. The relationships described in paragraph A above are as follows:
   1. A director, officer, or partner of the DBPM;
   2. A person with beneficial ownership of five percent (5%) or more of the DBPM's equity; or
   3. A person with an employment, consulting or other arrangement with the DBPM for the provision of items and services which are significant and material to the DBPM's obligations.

4. Excluded Providers

Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for emergency dental services. The DBPM is responsible for the return of any money paid for services provided by an excluded provider.

5. Reporting

A. In accordance with 42 CFR §455.1(a)(1) and §455.17, the DBPM shall be responsible for promptly reporting suspected fraud, abuse, waste, and neglect information to LDH and MFCU within three (3) business days of discovery, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s). Additionally, the DBPM shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the DBPM or DBPM 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 DBPM or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

B. The DBPM, through its compliance officer, shall report all activities on a quarterly basis to LDH. If fraud, abuse, waste, neglect and overpayment issues are suspected, the DBPM compliance officer shall report it to LDH immediately upon discovery. Reporting shall include, but are not limited to:
   1. Number of complaints of fraud, abuse, waste, neglect and overpayments made to the DBPM that warrant preliminary investigation (defined at 42 CFR §455.14);
   2. Number of complaints reported to the Compliance Officer; and
   3. For each complaint that warrants investigation (defined at 42 CFR §455.15 and §455.16), the DBPM shall provide LDH, at a minimum, the following:
      - Name and ID number of provider and member involved if available;
      - Source of complaint;
      - Type of provider;
      - Nature of complaint;
      - Approximate dollars involved if applicable; and
      - Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.
   4. The DBPM, through its compliance officer, shall attest monthly to LDH that a search of the required databases has been completed to capture all exclusions.

C. Dental Records

1. The DBPM shall have a method to verify that services for which reimbursement was made, were provided to members. The DBPM shall have policies and procedures to maintain, or require DBPM providers and contractors to maintain, an individual dental record for each member. The DBPM shall ensure the dental record is:
   a) Accurate and legible;
   b) 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
   c) Readily available for review and provides dental and other clinical data required for Quality and Utilization Management review.

2. The DBPM shall ensure the dental record includes, minimally, the following:
   a) Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);
   b) Primary language spoken by the member and any translation needs of the member;
   c) Services provided through the DBPM, date of service, service site, and name of service provider;
   d) 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 DBPM;
   e) Referrals including follow-up and outcome of referrals;
   f) Documentation of emergency and/or after-hours encounters and follow-up;
   g) Signed and dated consent forms (as applicable);
   h) Documentation of advance directives, as appropriate; and
   i) Documentation of each visit, which must include:
      - Date and begin and end times of service;
      - Chief complaint or purpose of the visit;
      - Diagnoses or dental 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.,* DDS) and the signature or initials of the provider; and
      - Initials of providers must be identified with correlating signatures.
   j) The DBPM must provide one (1) free copy per calendar year of any part of member's record upon member's request.
   k) All documentation and/or records maintained by the DBPM or any and all of its network providers shall be maintained for at least six (6) years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.

D. Rights of Review and Recovery by DBPM and LDH
   1. The DBPM is responsible for investigating possible acts of provider fraud, abuse, and waste for all services under this contract, including those services that the DBPM subcontracts to outside entities.
   2. The DBPM has the exclusive right of review and recovery for twelve (12) months 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. No such notice shall be required in instances resulting from suspected fraud, which the DBPM has identified and referred to the Department, the Medicaid Fraud Control Unit, or other appropriate law

enforcement agency. A "complex" review is one for which a review of medical, financial and/or other records is necessary to determine the existence of a mispayment.

3. The DBPM shall complete its review and notify the provider of the results of such review within sixty (60) days of the date of receipt of documentation from the provider, not to exceed one hundred and twenty (120) days of the date of the notice to the provider. The DBPM shall notify the Department, on at least a quarterly basis, the results of reviews as well as instances of suspected fraud.
4. The DBPM shall not retain the exclusive right of review and/or recovery beyond twelve (12) months from the original date of service of a claim for a "complex" review, but the DBPM may conduct audits of providers' claims for a five (5) year period from the date of service of a claim. Such audits must be communicated to the Department at least quarterly.
5. If the DBPM does not initiate action with respect to a "complex" claim review within the twelve (12) month-period from the date of service of the claim, the Department or its agent may recover from the provider any overpayment which they identify and said recovered funds will be returned to the State.
6. The DBPM 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 mispayments 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 a mispayment. No additional documentation is required to be submitted from the provider to determine the existence of an overpayment.
7. LDH may recover from the provider any overpayments which it identifies through an "automated" review and said recovered funds will be returned to the State.
8. LDH must notify the DBPM of an identified mispayment from a "complex" or "automated" review prior to notifying any providers. The DBPM shall have thirty (30) calendar days from the date of notification of potential mispayments to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department or its agent.
9. The DBPM shall not correct the claims nor initiate an audit on the claims upon notification by the Department or its agent.
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, the Department or its agent will notify the DBPM and the DBPM shall initiate a payment withhold on the provider in the amount due to the Department. The DBPM shall collect and refund the overpayment to the Department

D. Technical Requirements

4. General Requirements

A. The Contractor must maintain hardware and software compatible with current LDH requirements which are as follows:
   1. The contractor is responsible for procuring and maintaining hardware and software resources which are sufficient to successfully perform the services detailed in this contract.
   2. The contractor should adhere to federal regulations and guidelines as well as industry standards and best practices for systems or functions required to support the requirements of this contract.
   3. Unless explicitly stated to the contrary, the contractor is responsible for all expenses required to obtain access to LDH systems or resources which are relevant to successful completion of the requirements of this contract. The contractor is also responsible for expenses required for LDH to obtain access to the Contractor's systems or resources which are relevant to the successful completion of the requirements of this contract. Such expenses

are inclusive of hardware, software, network infrastructure and any licensing costs.

4. Any confidential information must be encrypted to FIPS 140-2 standards when at rest or in transit.
5. Contractor owned resources must be compliant with industry standard physical and procedural safeguards for confidential information (NIST 800-53A, ISO 17788, etc.).
6. Any contractor use of flash drives or external hard drives for storage of LDH data must first receive written approval from the Department and upon such approval shall adhere to FIPS 140-2 hardware level encryption standards.
7. All contractor utilized computers and devices must:
   a) Be protected by industry standard virus protection software which is automatically updated on a regular schedule; and
   b) Have installed all security patches which are relevant to the applicable operating system and any other system software.

B. The DBPM shall maintain an automated Management Information System (MIS), hereafter referred to as System, which accepts and processes provider claims, verifies eligibility, collects and reports encounter data and validates prior authorization that complies with LDH and federal reporting requirements. The DBPM shall ensure that its System meets the requirements of the Contract, state issued Guides (See DBP Systems Companion Guide) 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.

C. The DBPM's application systems foundation shall employ the relational data model in its database architecture, which would entail the utilization of a relational database management system (DBPMS) such as Oracle®, DB2®, or SQL Server®. It is important that the DBPM's application systems support query access using Structured Query Language (SQL). Other standard connector technologies, such as Open Database Connectivity (ODBC) and/or Object Linking and Embedding (OLE), are desirable.

D. All the DBPM's applications, operating software, middleware, and networking hardware and software shall be able to interoperate as needed with LDH's systems and shall conform to applicable standards and specifications set by LDH.

E. The DBPM's System shall have, and maintain, capacity sufficient to handle the workload projected for the begin date of operations and shall be scalable and flexible so that it can be adapted as needed, within negotiated timeframes, in response to changes in the contract requirements.

5. **HIPAA Standards and Code Sets**

A. The System shall be able to transmit, receive and process data in current HIPAA-compliant or LDH specific formats and/or methods, including, but not limited to, secure File Transfer Protocol (FTP) over a secure connection such as a Virtual Private Network (VPN). Data elements and file format requirements may be found in the DBP Systems Companion Guide.

B. All HIPAA-conforming exchanges of data between LDH and the DBPM shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker.

C. The System shall conform to the following HIPAA-compliant standards for information exchange. Batch transaction types include, but are not limited to, the following:

1. ASC X12N 835 Claims Payment Remittance Advice Transaction;
2. ASC X12N 837I Institutional Claim/Encounter Transaction;
3. ASC X12N 837D Dental Claim/Encounter;
4. ASC X12N 837P Professional Claim/Encounter Transaction;
5. ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;
6. ASC X12N 276 Claims Status Inquiry;

7. ASC X12N 277 Claims Status Response;
8. ASC X12N 278 Utilization Review Inquiry/Response; and
9. ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products.

D. The DBPM shall not revise or modify the standardized forms or formats.
E. Transaction types are subject to change and the DBPM shall comply with applicable federal and HIPAA standards and regulations as they occur.
F. The DBPM shall comply with national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with LDH. These shall include, but not be limited to, HIPAA based standards, federal safeguard requirements including signature requirements described in the CMS State Medicaid Manual.

6. **Connectivity**
   A. LDH shall require that the DBPM interface with LDH, the Medicaid Fiscal Intermediary (FI), and its trading partners. The DBPM must have capacity for real time connectivity to all LDH approved systems. The DBPM must have the capability to allow approved LDH personnel to access internal applications to permit inquiry of eligibility, claims, encounters, reference, provider and other data. The access method should be real-time and may be coordinated with LDH via remote network connections.
   B. The System shall conform and adhere to the data and document management standards of LDH and its FI, inclusive of standard transaction code sets.
   C. The DBPM's Systems shall utilize mailing address standards in accordance with the United States Postal Service.
   D. At such time that LDH requires, the DBPM shall participate and cooperate with LDH to implement, within a reasonable timeframe, a secure, web-accessible health record for members, such as Personal Health Record (PHR) or Electronic Health Records (EHR).
   E. At such time that LDH requires, the DBPM shall participate in statewide efforts to incorporate all provider information into a statewide health information exchange.
   F. The DBPM shall meet, as requested by LDH, with work groups or committees to coordinate activities and develop system strategies that actively reinforce the healthcare reform initiative.
   G. 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 LDH. The DBPM is expressly prohibited from sharing or publishing LDH's information and reports without the prior written consent of LDH. In the event of a dispute regarding the sharing or publishing of information and reports, LDH's decision on this matter shall be final.
   H. The Medicaid Management Information System (MMIS) is responsible for the processing and payment of Fee-for-service claims to providers and the timely and accurate reporting to state and federal personnel and private sector partners for covered Medicaid services.
   I. The DBPM shall be responsible for all initial and recurring costs required for access to LDH system(s), as well as LDH access to the DBPM's system(s). These costs include, but are not limited to, hardware, software, licensing, and authority/permission to utilize any patents, annual maintenance, support, and connectivity with LDH and the Fiscal Intermediary (FI).
   J. If required by LDH/BHSF, the DBPM shall complete an Information Systems Capabilities Assessment (ISCA), which will be provided by LDH. The ISCA shall be completed and returned to LDH no later than thirty (30) days from the date the DBPM signs the Contract with LDH.

7. **Network and Back-up Capabilities**
   A. Establish a local area network or networks as needed to connect all appropriate workstation personal desktop computers (PCs);
   B. Establish appropriate hardware firewalls, routers, and other security measures so that the DBPM's computer network is not able to be breached by an external entity;

C. Establish appropriate back-up processes that ensure the back-up, archival, and ready retrieval of network server data and desktop workstation data;
D. 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
E. The DBPM shall establish independent generator back-up power capable of supplying necessary power for a minimum of four (4) days.

8. **Resource Availability and Systems Changes**
   A. Resource Availability
      The DBPM shall provide Systems Help Desk services to LDH, its FI staff that have direct, real-time access to the data in the DBPM's Systems. The Systems Help Desk shall:
      1. Be available via local and toll-free telephone service, and via email from 7:00 a.m. to 7:00 p.m., Central Time, Monday through Friday, with the exception of state holidays. Upon request by LDH, the DBPM shall be required to staff the Systems Help Desk on a state holiday, Saturday, or Sunday;
      2. Answer questions regarding the DBPM's System functions and capabilities; report recurring programmatic and operation problems to appropriate staff for follow-up; redirect problems or queries that are not supported by the Systems Help Desk, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate LDH staff;
      3. Ensure individuals who place calls after hours are have the option to leave a message. The DBPM's staff shall respond to messages left between the hours of 7:00 p.m. and 7:00 a.m. by noon that next business day;
      4. Ensure recurring problems not specific to Systems unavailability identified by the Systems Help Desk shall be documented and reported to DBPM management within one (1) business day of recognition so that deficiencies are promptly corrected; and
      5. Have an IS service management system that provides an automated method to record, track and report all questions and/or problems reported to the Systems Help Desk.

9. **Information Systems Documentation Requirements**
   A. The DBPM shall ensure that written Systems process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.
   B. The DBPM shall develop, prepare, print, maintain, produce, and distribute to LDH distinct Systems design and management manuals, user manuals and quick reference Guides, and any updates.
   C. The DBPM shall ensure the Systems user manuals contain information about, and instruction for, using applicable Systems functions and accessing applicable system data.
   D. The DBPM shall ensure when a System change is subject to LDH prior written approval, the DBPM will submit revision to the appropriate manuals before implementing said Systems changes.
   E. The DBPM shall ensure all aforementioned manuals and reference Guides are available in printed form and on-line; and
   F. The DBPM shall update the electronic version of these manuals immediately, and update printed versions within ten (10) business days of the update taking effect.
   G. The DBPM shall provide to LDH documentation describing its Systems Quality Assurance Plan.

10. **Systems Changes**

    A. The DBPM's Systems shall conform to future federal and/or LDH specific standards for encounter data exchange within ninety (90) calendar days prior to the standard's effective date or earlier, as directed by CMS or LDH.

B. If a system update and/or change are necessary, the DBPM shall draft appropriate revisions for the documentation or manuals, and present to LDH thirty (30) days prior to implementation, for LDH review and approval. Documentation revisions shall be accomplished electronically and shall be made available for Department review in an easily accessible, near real-time method. Printed manual revisions shall occur within ten (10) business days of the actual revision.
C. The DBPM shall submit written notice as an alert to LDH within ten (10) calendar days of identification of a required system update, change or "fix". This written notice shall include an overview of the system problem and its potential impact to providers, with the DBPM's estimated timeframe for implementation of a correction. The DBPM shall notify LDH of changes to its System within its span of control, ninety (90) calendar days prior to the projected date of the change, or within a timeframe specified and approved by LDH.
D. Changes include, but are not limited to major changes, upgrades, modification or updates to application or operating software associated with the following core production System:
    1. Claims processing;
    2. Eligibility and enrollment processing;
    3. Service authorization management;
    4. Reference file processing (*e.g.,* procedure formularies, approved diagnoses, provider payment rates, etc.);
    5. Provider enrollment and data management; and
    6. Conversions of core transaction management Systems.
E. The DBPM shall respond to LDH notification of System problems not resulting in System unavailability according to the following timeframes:
    1. Within five (5) calendar days of receiving notification from LDH, the DBPM shall respond in writing to notices of system problems.
    2. Within fifteen (15) calendar days, the correction shall be made or a written corrective action plan will be due.
    3. The DBPM shall correct the deficiency by an effective date to be determined by LDH.
    4. The DBPM's Systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.
    5. The DBPM shall put in place procedures and measures for safeguarding against unauthorized modification to the DBPM's Systems.
F. Unless otherwise agreed to in advance by LDH, the DBPM shall not schedule Systems unavailability to perform system maintenance, repair and/or upgrade activities to take place during hours that can compromise or prevent critical business operations.
G. The DBPM shall work with LDH pertaining to any testing initiative as required by LDH and shall provide sufficient system access to allow testing by LDH and/or its FI of the DBPM's System.

11. **Systems Refresh Plan**
    A. The DBPM shall provide to LDH an annual Systems Refresh Plan. The plan shall outline how Systems within the DBPM's span of control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors.
    B. The systems refresh plan shall also indicate how the DBPM will ensure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the Systems component.

12. **Other Electronic Data Exchange**

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

13. **Electronic Messaging**
    A. The DBPM shall provide a continuously available electronic mail communication link (email system) to facilitate communication with LDH. This email system shall be capable of attaching and sending documents created using software compatible with LDH's installed version of Microsoft Office (currently 2016) and any subsequent upgrades as adopted.
    B. As needed, the DBPM shall be able to communicate with LDH over a secure Virtual Private Network (VPN).
    C. The DBPM shall comply with national standards for submitting public health information (PHI) electronically and shall set up a secure emailing system that is password protected for both sending and receiving any personal health information.

14. **Member Enrollment**

    The DBPM shall:
    A. Receive, process and update enrollment files sent daily by the Fiscal Intermediary;
    B. Update its eligibility and enrollment databases within twenty-four (24) hours of receipt of said files;
    C. Transmit to LDH, in the formats and methods specified by LDH, member address changes and telephone number changes;
    D. Be capable of uniquely identifying a distinct Medicaid member across multiple populations and Systems within its span of control; and
    E. Be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by LDH, resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

15. **Provider Enrollment**
    A. At the onset of the DBPM Contract and periodically as changes are necessary, LDH shall publish at www.lamedicaid.com the list of Louisiana Medicaid provider types, specialty, and sub-specialty codes. In order to coordinate provider enrollment records, the DBPM shall utilize the published list of Louisiana Medicaid provider types, specialty, and sub-specialty codes in all provider data communications with LDH and the FI. The DBPM shall provide the following:

        1. Provider service name, Provider billing name/DBA name, service/practice address (street, city, state, zip+4), billing address (street, city, state, zip+4), alternate practice site address (if appropriate: street, city, state, zip+4), licensing information (including effective date(s)), Tax ID/SSN, National Provider Identifier (NPI), taxonomy and bank direct deposit/EFT payment information;
        2. All relevant provider ownership information as prescribed by LDH, federal or state laws; and
        3. Performance of all federal or state mandated exclusion background checks on all providers (owners and managers). The providers shall perform the same for all their employees at least annually.

B. Provider enrollment systems shall include, at minimum, the following functionality:
   1. Audit trail and history of changes made to the provider file;
   2. Automated interfaces with all licensing and dental boards;
   3. Automated alerts when provider licenses are nearing expiration;
   4. Verification and Retention of NPI requirements;
   5. System generated letters to providers when their licenses are nearing expiration;
   6. Linkages of individual providers to groups;
   7. Credentialing information;
   8. Provider office hours; and
   9. Provider languages spoken.

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

16. **Information Systems Availability**

The DBPM shall:

A. Not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the DBPM's span of control;
B. Allow CMS, LDH personnel, agents of the Louisiana Attorney General's Office or individuals authorized by LDH 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;
C. 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 LDH and the DBPM. Unavailability caused by events outside of the DBPM's span of control is outside of the scope of this requirement;
D. Ensure that at a minimum all other System functions and information are available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m., Central Time, Monday through Friday;
E. Ensure that the systems and processes within its span of control associated with its data exchanges with LDH's FI and its contractors are available and operational;
F. Ensure that in the event of a declared major failure or disaster, the DBPM'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;
G. Notify designated LDH staff via phone, fax and/or electronic mail within sixty (60) minutes upon discovery of a problem within or outside the DBPM's span of control that may jeopardize or is jeopardizing availability and performance of critical systems functions and the availability of critical information as defined in this Section, including any problems impacting scheduled exchanges of data between the DBPM and LDH or LDH's FI. In its notification, the DBPM shall explain in detail the impact to critical path processes such as enrollment management and encounter submission processes;
H. Notify designated LDH staff via phone, fax, and/or electronic mail within fifteen (15) minutes upon discovery of a problem that results in delays in report distribution or problems in 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;
I. Provide information on System unavailability events, as well as status updates on problem resolution, to appropriate LDH staff. At a minimum these updates shall be provided on an hourly basis and made available via phone and/or electronic mail;

J. Resolve and implement system restoration within sixty (60) minutes of official declaration of unscheduled System unavailability of critical functions caused by the failure of system and telecommunications technologies within the DBPM's span of control. Unscheduled System unavailability to all other System functions caused by system and telecommunications technologies within the DBPM's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability. Cumulative Systems unavailability caused by systems and/or IS infrastructure technologies within the DBPM's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period; and

K. Within five (5) business days of the occurrence of a problem with system availability, the DBPM shall provide LDH with full written documentation that includes a corrective action plan describing how the DBPM will prevent the problem from reoccurring.

17. **Contingency Plan**

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

B. 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.

C. The DBPM shall have a Contingency Plan that must be submitted to LDH for approval.

D. At a minimum, the Contingency Plan shall address the following scenarios:
   1. The central computer installation and resident software are destroyed or damaged;
   2. The system interruption or failure resulting from network, operating hardware, software, or operations errors that compromise the integrity of transaction that is active in a live system at the time of the outage;
   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;
   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
   5. The Plan shall specify projected recovery times and data loss for mission-critical Systems in the event of a declared disaster.

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

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

15. **Offsite Storage and Remote Backup**

A. The DBPM shall provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.
B. The data back-up policy and procedures shall include, but not be limited to:
   - Descriptions of the controls for back-up processing, including how frequently back-ups occur;
   - Documented back-up procedures;
   - The location of data that has been backed up (off-site and on-site, as applicable);
   - Identification and description of what is being backed up as part of the back-up plan; and
   - Any change in back-up procedures in relation to the DBPM's technology changes.
C. LDH shall be provided with a list of all back-up files to be stored at remote locations and the frequency with which these files are updated.

16. **Records Retention**
A. The DBPM shall have online retrieval and access to documents and files for six (6) years in live systems for audit and reporting purposes, ten (10) years in archival systems. Services which have a once in a life-time indicator (*i.e.,* Surgical Removal of Erupted Tooth) are denoted on LDH's procedure formulary file and claims shall remain in the current/active claims history that is used in claims editing and are not to be archived or purged. Online access to claims processing data shall be by the Medicaid recipient ID, provider ID and/or ICN (internal control number) to include pertinent claims data and claims status. The DBPM shall provide forty-eight (48) hour turnaround or better on requests for access to information that is 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.
B. The historical encounter data submission shall be retained for a period not less than six (6) years, following generally accepted retention guidelines.
C. 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. **Information Security and Access Management**
The DBPM's system shall:
A. Employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:
   1. Restrict access to information on a "least privilege" basis, such as users permitted inquiry privileges only, will not be permitted to modify information;
   2. Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions shall be restricted to specified staff jointly agreed to by LDH and the DBPM; and
   3. Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.
B. Make System information available to duly authorized representatives of LDH and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.
C. Contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in

periodic and spot audits following a methodology to be developed by the DBPM and LDH.

D. 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:
   1. Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;
   2. Have the date and identification "stamp" displayed on any on-line inquiry;
   3. Have the ability to trace data from the final place of recording back to its source data file and/or document;
   4. Be supported by listings, transaction reports, update reports, transaction logs, or error logs; and
   5. Facilitate auditing of individual records as well as batch audits.

E. Have inherent functionality that prevents the alteration of finalized records;

F. Provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The DBPM shall provide LDH with access to data facilities upon request. The physical security provisions shall be in effect for the life of the Contract;

G. 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;

H. 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;

I. Put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of the DBPM's span of control. This includes, but is not limited to, any provider or member service applications that are directly accessible over the Internet, shall be appropriately isolated to ensure appropriate access;

J. Ensure that remote access users of its Systems can only access said Systems through two-factor user authentication and via methods such as a Virtual Private Network (VPN); and

K. Comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. As a minimum, the DBPM shall conduct a security risk assessment and communicate the results in an information security plan provided no later than fifteen (15) calendar days after the Contract award. The risk assessment shall also be made available to appropriate federal agencies.

18. **Systems Audit Requirements**

A. State Audits
   1. The DBPM shall provide to state auditors (including legislative auditors), upon written request, files for any specified accounting period that a valid Contract exists in a file format or audit defined media, magnetic tapes, CD or other media compatible with LDH and/or state auditor's facilities. The DBPM shall provide information necessary to assist the state auditor in processing or utilizing the files.
   2. If the auditor's findings point to discrepancies or errors, the DBPM shall provide a written corrective action plan to LDH within ten (10) business days of receipt of the audit report.
   3. At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the state auditors. These findings shall be reviewed by LDH and integrated into the DBPM's EDP manual.

B. Independent Audits
   1. The DBPM shall be required to contract with an independent firm, subject to the written approval of LDH, which has experience in conducting systems and compliance audits in accordance with applicable federal and state

auditing standards for applications comparable with the scope of the Contract's Systems application. These requirements are also applicable to any subcontractors or vendors delegated the responsibility of adjudicating claims on behalf of the DBPM.

2. The independent firm shall perform a comprehensive audit on a calendar year basis, for controls placed in operation and operation effectiveness, to determine the DBPM's compliance with the obligations specified in the Contract and the Systems Companion Guide.
3. The auditing firm shall deliver to the DBPM and to LDH a report of findings and recommendations by March 31st of each year. The report shall be prepared in accordance with generally accepted auditing standards for EDP application reviews.
4. LDH shall use the findings and recommendations of each report as part of its monitoring process.
5. The DBPM shall deliver to LDH a corrective action plan to address deficiencies identified during the audit within ten (10) business days of receipt of the audit report. At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the independent auditing firm. These findings are reviewed by LDH and shall become a part of the DBPM's EDP manual.
6. Audits shall include a scope necessary to fully comply with the Statement on Standards for Attestation Engagements no. 16 (SSAE 16) issued by the Auditing Standards Board of the American Institute of Certified Public Accounts.

19. **Claims Management**

A. Electronic Claims Management (ECM) Functionality

1. The DBPM shall annually comply with LDH's electronic data interchange (EDI) policies for certification of electronically submitted claims.
2. To the extent that the DBPM compensates providers on a FFS or other basis requiring the submission of claims as a condition of payment, the DBPM shall process the provider's claims for covered services provided to members, consistent with applicable DBPM policies and procedures and the terms of the Contract and the Systems Companion Guide, including, but not limited to, timely filing guidelines, and compliance with all applicable state and federal laws, rules and regulations. Timely filing guidelines are:
   a) Medicaid-only claims must be filed within three hundred sixty-five (365) days from the date of service.
   b) 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.
   c) The DBPM must deny any claim not initially submitted to the DBPM by the three hundred and sixty-fifth (365) calendar day from the date of service, unless LDH, the DBPM or its subcontractors created the error. The DBPM shall not deny claims solely for failure to meet timely filing guidelines due to error by LDH, the DBPM, or its subcontractors.
   d) For purposes of DBP 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.
   e) The DBPM shall not deny claims submitted in cases of retroactive eligibility for failure to meet timely filing guidelines if the claims are submitted within one hundred and eighty (180) days from the member's enrollment in the DBPM.
3. The DBPM shall maintain an electronic claims management system that will:
   a) Uniquely identify the attending and billing provider NPI of each service;
   b) Identify the date of receipt of the claim (the date the DBPM receives the claim and encounter information);

c) Identify real-time accurate history with dates of adjudication results of each claim such as paid, denied, pended, appealed, etc., and follow up information on appeals;
d) Identify the date of payment, the date & number of the check or other form of payment such as electronic funds transfer (EFT);
e) Identify all data elements as required by LDH for electronic encounter data submission as stipulated in this Section of the contract and the Systems Companion Guide; and
f) Allow submission of non-electronic and electronic claims by contracted providers.

4. The DBPM shall ensure that an electronic claims management (ECM) capability that accepts and processes claims submitted electronically is in place.
5. The DBPM shall ensure the ECM system shall function in accordance with information exchange and data management requirements as specified in this Section of the contract and the Systems Companion Guide.
6. The DBPM shall ensure that as part of the ECM function it can provide on-line and phone-based capabilities to obtain processing status information.
7. The DBPM shall support access to an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.
8. The DBPM shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the DBPM or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees and/or charges.
9. The DBPM shall require that their providers comply at all times with the American Dental Association (ADA) National coding standards (ADA form), and standardized billing forms and formats, and all future updates for Dental and Professional claims (CMS 1500).
10. The DBPM must comply with requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010, regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies implemented as a result of this initiative.
11. The DBPM agrees that at such time that LDH presents recommendations concerning claims billing and processing that are consistent with industry norms, the DBPM shall comply with said recommendations within ninety (90) calendar days from notice by LDH.
12. The DBPM shall have procedures approved by LDH, available to providers in written and web form for the acceptance of claim submissions which include:
    a) The process for documenting the date of actual receipt of non-electronic claims and date and time of electronic claims;
    b) The process for reviewing claims for accuracy and acceptability;
    c) The process for prevention of loss of such claims, and
    d) The process for reviewing claims for determination as to whether claims are accepted as clean claims.
13. The DBPM shall have a procedure approved by LDH available to providers in written and web form for notifying providers of batch rejections. The report, at a minimum, should contain the following information:
    a) Date batch was received by the DBPM;
    b) Date of rejection report;
    c) Name or identification number of DBPM issuing batch rejection report;
    d) Batch submitters name or identification number; and
    e) Reason batch is rejected.
14. The DBPM shall assume all costs associated with claim processing, including the cost of reprocessing/resubmission, due to processing errors caused by the DBPM or to the design of systems within the DBPM's span of control.

15. The DBPM shall not employ off-system or gross adjustments when processing correction to payment error, unless it requests and receives prior written authorization from LDH.
16. For purposes of network management, the DBPM shall notify all contracted providers to file claims associated with covered services directly with the DBPM, or its contractors, on behalf of Louisiana Medicaid members.
17. At a minimum, the DBPM shall run one (1) provider payment cycle per week, on the same day each week, as determined by the DBPM and approved by LDH.

B. Claims Processing Methodology Requirements

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

1. Confirming eligibility on each member as claims are submitted on the basis of the eligibility information provided by LDH and the FI that applies to the period during which the charges were incurred;
2. A review of the entire claim within five (5) working days of receipt of an electronic claim, to determine that the claim is not a clean claim and issue an exception report to the provider indicating all defects or reasons known at that time that the claim is not a clean claim. The exception report shall contain at a minimum the following information:
   a) Member name;
   b) Provider claim number, patient account number, or unique member identification number;
   c) Date of service;
   d) Total billed charges;
   e) DBPM's name; and
   f) The date the report was generated.
3. Medical necessity;
4. Prior Approval – The system shall determine whether a covered service required prior approval and if so, whether the DBPM granted such approval;
5. Duplicate Claims – The system shall in an automated manner, flag a claim as being exactly the same as a previously submitted claim or a possible duplicate and either deny or pend the claim as needed;
6. Covered Services - Ensure that the system can verify that a service is a covered service and is eligible for payment;
7. 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;
8. Quantity of Service - Ensure that the system shall evaluate claims for services provided to members to ensure that any applicable benefit limits are applied; and
9. Perform system edits for valid dates of service, and ensure that dates of services are valid dates such as not in the future or outside of a member's Medicaid eligibility span.

C. Explanation of Benefits

1. The DBPM shall within forty-five (45) calendar days of payment of claims, provide individual notices, Explanation of Benefits (EOBs), to a sample group of the members who received services. The required notice must specify:
   - 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.
2. The DBPM shall also:

a) Include in the sample, claims for services with hard benefit limits, denied claims with member responsibility, and paid claims (excluding ancillary and anesthesia services);
b) Stratify paid claims sample to ensure that all provider types (or specialties) and all claim types are proportionally represented in the sample pool from the entire range of services available under the contract. To the extent that the DBPM considers a particular specialty (or provider) to warrant closer scrutiny, the DBPM may over sample the group. The paid claims sample should be for a minimum of two hundred (200) to two hundred-fifty (250) claims per year to be reported on a quarterly basis;
c) 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); and
d) The DBPM shall track any complaints received from members and resolve the complaints according to its established policies and procedures. The resolution may be member education, provider education, or a referral to LDH. The DBPM shall use the feedback received to modify or enhance the EOB sampling methodology.
e) Within three (3) business days, results indicating that paid services may not have been received, shall be referred to the DBPM's fraud and abuse department for review and to LDH through the following url: http://new.dhh.louisiana.gov/index.cfm/page/219.
f) 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 complaint resolution, and number of surveys referred to LDH for further review.

D. Remittance Advices

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

- The name of the member;
- Unique member identification number;
- Patient claim number or patient account number;
- Date of service;
- Total provider charges;
- Member liability, specifying any co-insurance, deductible, copayment, or non-covered amount;
- Amount paid by the DBPM;
- Amount denied and the reason for denial;
- Adjustments and Voids shall appear on the RA under "Adjusted or Voided claims" either as Approved or Denied; and
- 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."

E. Adherence to Key Claims Management Standards

1. Prompt Payment to Providers
   a) The DBPM shall ensure that ninety percent (90%) of all clean claims for payment of services delivered to a member are paid by the DBPM to the provider within fifteen (15) business days of the receipt of such claims.
   b) The DBPM shall process and, if appropriate, pay within thirty (30) calendar days, ninety-nine percent (99%) of all clean claims to providers for covered services delivered to a member.

c) If a clean claim is denied on the basis the provider did not submit required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall not constitute a new claim for purposes of establishing the timeframe for timely filing.
d) 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 DBPM, or if a time period is not specified in the contract:
   i. The tenth (10th) day of the calendar month if the payment is to be made by a contractor, or
   ii. If the DBPM is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting member roster information from LDH.
e) The DBPM 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. In situations of third party benefits, the timeframes for filing a claim shall begin on the date that the third party completes resolution of the claim.
f) The DBPM shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or CHIP program pursuant to Section 1128 or 1156 of the Social Security Act or is otherwise not in good standing with LDH.
g) Within five (5) business days of receipt of a claim, the DBPM shall perform an initial screening, and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication.
h) Fully adjudicate (pay or deny) all pended claims within sixty (60) calendar days of the date of receipt.

2. Claims Dispute Management
   a) The DBPM shall develop an internal claims dispute process for those claims or group of claims that have been denied or for which the payment has been reduced. The process must be submitted to LDH for approval.
   b) The claims dispute management process must include, at a minimum, the following components:
      i. A designated telephone number for provider relations staff so that if a provider has a question or is not satisfied with the information they have received related to a claim, they can contact appropriate staff;
      ii. Specific timeframes during which time all requests for claim reconsideration or adjustment must be received;
      iii. Guidelines for submitting a paper claim for review or reconsideration; and
      iv. A list of required information for submission of requests for claim reconsideration or adjustment in either electronic or paper format.
   c) The DBPM shall systematically capture the status and resolution of all claim disputes as well, as all associated documentation.
   d) The DBPM shall adjudicate all disputed claims to a paid or denied status within (30) business days of receipt of the disputed claim.
   e) The DBPM shall resolve all claims, including disputed claims, no later than twenty-four (24) months of the date of service.

3. Claims Payment Accuracy Report
   a) On a monthly basis, the DBPM shall submit a claims payment accuracy percentage report to LDH. A copy of the report format and instructions is provided in the Systems Companion Guide. The report shall be based

on an audit conducted by the DBPM. The audit shall be conducted by an entity or staff independent of claims management as specified in this Section of the contract, 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.

b) The minimum attributes to be tested for each claim selected shall include:
   i. Claim data correctly entered into the claims processing system;
   ii. Claim is associated with the correct provider;
   iii. Proper authorization was obtained for the service;
   iv. Member eligibility at processing date correctly applied;
   v. Allowed payment amount agrees with contracted rate;
   vi. Duplicate payment of the same claim has not occurred;
   vii. Denial reason applied appropriately;
   viii. Copayment application considered and applied, if applicable;
   ix. Effect of modifier codes correctly applied; and
   x. Proper coding.

c) The results of testing at a minimum should be documented to include:
   i. Results for each attribute tested for each claim selected;
   ii. Amount of overpayment or underpayment for each claim processed or paid in error;
   iii. Explanation of the erroneous processing for each claim processed or paid in error;
   iv. Determination of whether 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
   v. Claims processed or paid in error have been corrected.

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

e) Encounter Data
   i. The DBPM's system shall be able to transmit to and receive electronic encounter data from the LDH FI's system as required for the appropriate submission of encounter data.
   ii. All encounters shall be submitted electronically in the standard HIPAA transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB Transaction formats (D – Dental, P - Professional, and I - Institutional). Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.
   iii. The DBPM shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided.
   iv. The DBPM shall have the ability to update CDT, CPT/HCPCS, ICD-9-CM, ICD-10-CM and other codes based on HIPAA standards and move to future versions as required. In addition to CDT, CPT, ICD-9-CM, ICD-10-CM and other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the DBPM and LDH to evaluate performance measures. The DBPM will not be permitted to submit paper encounters to LDH's FI.
   v. The DBPM shall have the capability to convert all information that enters its claims system via hard copy paper claims to electronic encounter data, to be submitted in the appropriate HIPAA compliant formats to LDH's FI.
   vi. The FI encounter process shall utilize a LDH-approved version of the claims processing system (edits and adjudication) to identify valid and invalid encounter records from an electronic batch submission

by the DBPM. Any submission which contains fatal errors that prevent processing, or that does not satisfy defined threshold error rates, will be rejected and returned to the DBPM for immediate correction.

vii. LDH and its FI shall determine which claims processing edits are appropriate for encounters and shall set encounter edits to "pay" or "deny". Encounter denial codes shall be deemed "repairable" or "non-repairable". An example of a repairable encounter is "Date of Service is not valid". An example of a non-repairable encounter is "exact duplicate". The DBPM is required to be familiar with the FI exception codes and dispositions for the purpose of repairing denied encounters.

viii. As specified in the DBP Systems Companion Guide, denials for the following reasons will be of particular interest to LDH:
- Denied for Medical Necessity including lack of documentation to support necessity;
- Member has other insurance that must be billed first;
- Prior authorization not on file;
- Claim submitted after filing deadline; and
- Service not covered by DBPM.

ix. The DBPM shall utilize LDH provider billing manuals and become familiar with the claims data elements that must be included in encounters. The DBPM shall retain all required data elements in claims history for the purpose of creating encounters that are compatible with LDH and its FI's billing requirements.

x. Due to the need for timely data and to maintain integrity of processing sequence, the DBPM shall address any issues that prevent processing of an encounter; acceptable standards shall be ninety percent (90%) of reported repairable errors are addressed within thirty (30) calendar days and ninety-nine percent (99%) of reported repairable errors within sixty (60) calendar days or within a negotiated timeframe approved by LDH. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan may result in monetary penalties.

xi. For encounter data submissions, the DBPM shall submit ninety-five (95%) of its encounter data at least monthly due no later than the twenty-fifth (25th) calendar day of the month following the month in which they were processed and approved/paid, including encounters reflecting a zero dollar amount ($0.00) and encounters in which the DBPM has a capitation arrangement with a provider. The DBPM CEO or CFO shall attest to the truthfulness, accuracy, and completeness of all encounter data submitted.

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

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

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

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

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

xvii. The DBPM must make an adjustment to encounter claims when the DBP 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 LDH or its subcontractors discover errors or a conflict with a previously adjudicated encounter claim, the DBPM shall be required to adjust or void the encounter claim within (14) calendar days of notification by LDH or if circumstances exist that prevent contractor from meeting this time frame a specified date shall be approved by LDH.

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

E. Subcontracting

The contractor shall not contract with any other party for furnishing any of the work and professional services required by the contract without the express prior written approval of the Department. The contractor shall not substitute any subcontractor without the prior written approval of the Department. The contractor maintains the ultimate responsibility for complying with all the terms and conditions of its contract with the state. For subcontractor(s), before commencing work, the contractor will provide letters of agreement, contracts or other forms of commitment which demonstrate that all requirements pertaining to the contractor will be satisfied by all subcontractors through the following:

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

F. Insurance Requirements

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

1. Contractor's Insurance

The Contractor shall not commence work under this contract until it has obtained all insurance required herein, including but not limited to Automobile Liability Insurance, Workers' Compensation Insurance and General Liability Insurance. Certificates of Insurance, fully executed by officers of the Insurance Company shall be filed with the Department for approval. The Contractor shall not allow any subcontractor to commence work on subcontract until all similar insurance required for the subcontractor has been obtained and approved. If so requested, the Contractor shall also submit copies of insurance policies for inspection and approval of the Department before work is commenced. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days' written notice in advance to the Department and consented to by the Department in writing and the policies shall so provide.

2. Workers' Compensation Insurance

Before any work is commenced, the Contractor shall obtain and maintain during the life of the contract, Workers' Compensation Insurance for all of the

Contractor's employees employed to provide services under the contract. In case any work is sublet, the Contractor shall require the subcontractor similarly to provide Workers' Compensation Insurance for all the latter's employees, unless such employees are covered by the protection afforded by the Contractor. In case any class of employees engaged in work under the contract at the site of the project is not protected under the Workers' Compensation Statute, the Contractor shall provide for any such employees, and shall further provide or cause any and all subcontractors to provide Employer's Liability Insurance for the protection of such employees not protected by the Workers' Compensation Statute.

3. **Commercial General Liability Insurance**
   The Contractor shall maintain during the life of the contract such Commercial General Liability Insurance which shall protect Contractor, the Department, and any subcontractor during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as for claims for property damages, which may arise from operations under the contract, whether such operations be by the Contractor or by a subcontractor, or by anyone directly or indirectly employed by either of them, or in such a manner as to impose liability to the Department. Such insurance shall name the Department as additional insured for claims arising from or as the result of the operations of the Contactor or its subcontractors. In the absence of specific regulations, the amount of coverage shall be as follows: Commercial General Liability Insurance, including bodily injury, property damage and contractual liability, with combined single limits of $1,000,000.

4. **Insurance Covering Special Hazards**
   Special hazards as determined by the Department shall be covered by rider or riders in the Commercial General Liability Insurance Policy or policies herein elsewhere required to be furnished by the Contractor, or by separate policies of insurance in the amounts as defined in any Special Conditions of the contract included therewith.

5. **Licensed and Non-Licensed Motor Vehicles**
   The Contractor shall maintain during the life of the contract, Automobile Liability Insurance in an amount not less than combined single limits of $1,000,000 per occurrence for bodily injury/property damage. Such insurance shall cover the use of any non-licensed motor vehicles engaged in operations within the terms of the contract on the site of the work to be performed thereunder, unless such coverage is included in insurance elsewhere specified.

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

G. Contract Monitoring

The LDH/BHSF/ Medicaid Managed Care Program will be responsible for the primary oversight of the Contract, including Medicaid policy decision making and Contract interpretation. As appropriate, LDH will provide clarification of DBP requirements and Medicaid policy, regulations and procedures and will schedule meetings as necessary with the DBPM.

1. **Contact Personnel**
   A. The DBPM shall designate an employee of its administrative staff to act as the liaison between the DBPM and LDH for the duration of the Contract. Medicaid Managed Care Program staff will be the DBPM's 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 DBPM shall

also designate a member of its senior management who shall act as a liaison between the DBPM's senior management and LDH 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.

B. Contract Monitor

All work performed by the DBPM will be monitored by the Medicaid Director or his/her designee.

C. 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 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.

Medicaid Director or his/her designee
Louisiana Department of Health
Bureau of Health Services Financing
P.O. Box 91283
Bin 32
Baton Rouge, LA 70821-9283

MCNA Insurance Company, d/b/a MCNA Dental Plans
Carlos Lacasa, Senior Vice President and General Counsel
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, FL 33309

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 calendar days prior to the effective date of the change of address. If different representatives are designated after execution of the Contract, notice of the new representative will be given in writing to the other party and attached to originals of the Contract.

Whenever LDH is required by the terms of this contract to provide written notice to the DBPM, such notice will be signed by the Medicaid Director or his/her designee.

D. Notification of DBPM Policies and Procedures

LDH will provide the DBPM with updates to appendices, information and interpretation of all pertinent federal and state Medicaid regulations, DBPM policies, procedures and guidelines affecting the provision of services under this Contract. The DBPM will submit written requests to LDH for additional clarification, interpretation or other information. Provision of such information does not relieve the DBPM of its obligation to keep informed of applicable federal and state laws related to its obligations under this Contract.

E. Required Submissions

Within thirty (30) calendar days from the date the Contract is signed by the DBPM, the DBPM shall submit documents as specified in this contract. LDH shall have the right to approve, disapprove or require modification of these documents and any procedures, policies and materials related to the DBPM's responsibilities under the terms of the Contract.

F. Ongoing Contract Monitoring

1. LDH will monitor the DBPM's performance to ensure that the DBPM is in compliance with the Contract provisions. However this does not relieve the DBPM of its responsibility to continuously monitor its providers' performance in compliance with the Contract provisions.
2. LDH or its designee shall coordinate with the DBPM to establish the scope of review, the review site, relevant time frames for obtaining information, and the criteria for review.
3. LDH or its designee will, at a minimum annually, monitor the operation of the DBPM for compliance with the provisions of this Contract, and applicable federal and state laws and regulations. Inspection may include the DBPM's facilities, as well as auditing and/or review of all records developed under this Contract including, but not limited to, periodic dental audits, grievances, enrollments, disenrollment, utilization and financial records, review of the management systems and procedures developed under this Contract and any other areas or materials relevant or pertaining to this Contract.
4. The DBPM shall provide access to documentation, dental records, premises, and staff as deemed necessary by LDH.
5. The DBPM 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 LDH finalizes the results of monitoring and/or audit report, the DBPM 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.

G. DBPM On-Site Reviews

LDH will conduct on-site readiness reviews as an ongoing activity during the Contract period. The DBPM's on-site review will include a desk audit and on-site focus component. The site review will focus on specific areas of DBPM 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
- Primary care dentist assignments and changes
- Member grievances and appeals
- Health education and promotion
- Quality improvement
- Utilization review
- Data reporting
- Coordination of care
- Claims processing
- Fraud and abuse

H. Monitoring Reports

LDH will require the DBPM to submit monthly, quarterly, and annual reports that will allow LDH to assess the DBPM's performance.

I. Corrective Action

When LDH establishes that the DBPM is out of compliance with any of the above monitored activities, the DBPM will be required to provide corrective action plans to ensure that the goals of the program will be met. LDH may assess liquidated damages commensurate with the offense and at its discretion as provided by the contract.

H. Payment Terms

The contractor shall submit deliverables in accordance with established timelines and shall submit itemized invoices monthly or as defined in the contract terms. Payment of invoices is subject to approval of the Medicaid Director or his/her designee. Continuation of payment is dependent upon available funding.

I. Administrative Actions, Corrective Action Plans, Monetary Penalties, and Sanctions

1. Administrative Actions

A. LDH shall notify the DBPM through a written Notice of Action its intention to take administrative action when it is determined the DBPM is deficient or non-compliant with requirements or deliverables of the Contract. Administrative actions exclude the assessment of monetary penalties and intermediate actions. Administrative actions include, but are not limited to:
   1. a warning through written notice or consultation;
   2. education requirement regarding program policies and billing procedures. The DBPM may be required by LDH to participate in a provider education program as a condition of continued participation. DBPM education programs may include a letter of warning or clarification on the use and format of provider manuals; instruction on the use of procedure codes; review of key provisions of the Medicaid Program; instruction on reimbursement rates; instructions on how to inquire about coding or billing problems; and quality/dental issues;
   3. review of prior authorization implementation processes;
   4. referral to the Louisiana Department of Insurance for investigation;
   5. referral for review by appropriate professional organizations;
   6. referral to the Office of the Attorney General for fraud investigation; and/or
   7. require submission of a corrective action plan (CAP).

2. Corrective Action Plan with the Assessment of Monetary Penalties

If LDH determines a CAP is required, the DBPM shall:

A. Submit a CAP, by the deadline specified by LDH, for the deficiencies identified by LDH.
B. Within fifteen (15) calendar days of receiving the CAP, LDH will either approve or disapprove the CAP in writing. If disapproved, the DBPM shall resubmit, (within ten (10) calendar days), a new CAP that addresses the deficiencies identified by LDH.
C. Once LDH has approved a CAP, it will monitor implementation of such a plan and set appropriate timelines to bring activities of the DBPM into compliance with state and federal regulations. LDH may monitor via required reporting on a specified basis and/or through on-site evaluations, the effectiveness of the plan. Before imposing intermediate sanctions, LDH shall give the DBPM timely written notice that explains the basis and nature of the sanction and any other due process protections that LDH elects to provide and shall provide notification to CMS.
D. The DBPM shall implement the CAP within the time frames specified by LDH.
E. If the initial or revised CAP is disapproved, LDH may at its discretion, may assess monetary penalties against Contractor until pending attainment of acceptable CAP has been approved
F. If the initial or revised CAP performance/outcomes are not achieved, LDH may at its discretion assess monetary penalties against the Contractor until acceptable performance has been obtained.
G. Whenever monetary penalties are assessed against the DBPM for failure to meet performance standards specified within the contract,, including failure to comply with any requirements established in a CAP, for a single occurrence that exceeds $25,000.00, LDH staff will meet with DBPM staff to discuss the

causes for the occurrence and to negotiate a reasonable plan for corrective action of the occurrence. Once a corrective action plan has been approved by LDH, collection of monetary penalties during the agreed upon corrective action period will be suspended. The corrective action plan must include a date certain for the correction of the occurrence. Should that date for correction be missed by the DBPM, the original schedule of monetary penalties will be reinstated, including collection of monetary penalties for the corrective action period, and monetary penalties will continue until satisfactory correction as determined by LDH of the occurrence has been made.

3. Monetary Penalties and Sanctions

A. Purpose

1. The purpose of establishing and imposing monetary penalties is to provide a means for LDH to obtain the services and level of performance required for successful operation of the Contract. LDH's failure to assess monetary penalties in one or more of the particular instances described herein will in no event waive the right for LDH to assess additional monetary penalties or actual damages.
2. 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 DBPM'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 DBPM in attempting to stay in compliance.
3. For purposes of this section, violations including individual, unrelated enrollees shall not be considered as arising out of the same action.

Monetary Penalties Table

Failed Deliverable	Sanction
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 contract. 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 DBPM 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 DBPM, 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 dental record review by LDH or its designee where the DBPM 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 DBPM members have begun to permit time for development and implementation of

	a system for exchanging data and training of staff and healthcare providers.
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 (100%) of all clean claims must be paid within thirty (30) calendar days of the date of receipt. The DBPM 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 adjudicated.	Five thousand dollars ($5,000.00) for the first quarter that the DBPM's claims performance percentages by claim type fall below the performance standard. Twenty-five thousand dollars ($25,000.00) per quarter for each additional quarter that the claims performance percentages by claim type fall below the performance standards. One thousand dollars ($1,000.00) per claim if the DBPM fails to timely pay interest.
Claims Summary Report	One thousand dollars ($1,000.00) per calendar day the report is late, inaccurate, or incomplete.
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 contract and the Quality Companion Guide.
Member and/or Provider Satisfaction Report(s)	Two thousand dollars ($2,000.00) per calendar day the report(s) are late or incorrect.
Member Services Activities	Five thousand dollars ($5,000.00) per calendar day for failure to provide access to primary care dentists that offer extended office hours as defined by the contract. 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. 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.
Member Call Center • Answer 90% of calls within 30 seconds • Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of calls of not more than five percent (5%)	One hundred dollars ($100.00) for each percentage point for each standard that fails to meet the requirements for a monthly reporting period. One hundred dollars ($100.00) for each 30 second time increment, or portion thereof, by which the DBPM's average hold time exceeds the maximum acceptable hold time.
Administrative Service	Failure which results in actual harm to a member, places a member at risk of imminent harm, or materially affects LDH's ability to administer the Program. Five thousand dollars ($5,000.00) per calendar day for each incident of non-compliance.
Provider Demographics	Five thousand dollars ($5,000.00) per calendar day for failure to provide and validate provider demographic data on a quarterly basis to ensure current, accurate, and clean data is on file for all contracted providers.

Provider Service Activities	Five thousand dollars ($5,000.00) 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. Five thousand dollars ($5,000.00) per calendar day for failure to furnish provider services functions from 7 a.m. to 5 p.m. Central Time, Monday through Friday to address non-emergency issues encountered by providers.
Provider Call Center • Answer ninety percent (90%) of calls within 30 seconds • Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of calls of not more than five percent (5%)	One hundred dollars ($100.00) for each percentage point for each standard that fails to meet the requirements for a monthly reporting period. One hundred dollars ($100.00) for each thirty (30) second time increment, or portion thereof, by which the DBPM's average hold time exceeds the maximum acceptable hold time.
Covered Services	Failure to provide a DBPM 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. Seventy-five hundred dollars ($7,500.00) per calendar day for each incident of non-compliance.
Management Information System	In the event of a declared major failure or disaster, the DBPM'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. Five thousand dollars ($5,000.00) per calendar day of non-compliance per parish.
Transfer of Data	The DBPM must transfer all data regarding the provision of covered services to members to LDH, at the sole discretion of LDH and as directed by LDH. Ten thousand dollars ($10,000.00) per calendar day that the data is late, inaccurate or incomplete.
Termination Transition Plan	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 One thousand dollars ($1,000.00) per calendar day the plan is late, inaccurate, or incomplete.
Ad Hoc Reports as required by this Contract or upon request by LDH.	Two thousand dollars ($2,000.00) per calendar day for each business day that a report is late or incorrect.
Member File Updates	Failure to upload all Member File updates prior to end of month reconciliation process with files submitted to the DBPM by the FI. Five thousand dollars ($5,000.00) for each occurrence of non-compliance.
Corrective Action Plan	Two thousand dollars ($2,000.00) per each calendar day the CAP is late or incorrect.
Network Adequacy	Ten thousand dollars ($10,000) per occurrence the DBPM has not meet the network adequacy requirements outlined in this contract.
Access Standards and Guidelines, Timeliness	One thousand dollars ($1,000) per occurrence the DBPM is not in compliance with network standards required by the contract.
Covered Services	Five thousand dollars ($5,000) per occurrence if a DBPM provider refuses to provide services without timely notifying beneficiaries or making alternative arrangements. One thousand dollars ($1,000) plus the cost of the service for a member in which the DBPM was asked

	to provide the service by LDH and refused to provide the core benefit or service(s).

4. LDH shall utilize the following guidelines to determine whether a report is correct and complete:
   - The report must contain 100% of the DBPM's data;
   - 99% of the required items for the report must be completed; and
   - 99.5% of the data for the report must be accurate as determined by edit specifications/review guidelines set forth by LDH.

B. Other Reporting and/or Deliverable Requirements
   1. For each day that a deliverable is late, incorrect or deficient, the DBPM may be liable to LDH 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 requirement/activity of noncompliance.
   2. Monetary penalties have been designed to escalate by duration and by occurrence over the term of this Contract, inclusive of any contract extensions.

Monetary Penalties Escalation Table

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

C. Employment of Key and Licensed Personnel
   1. Seven hundred dollars ($700.00) per calendar day for failure to have a full-time acting or permanent Executive Director for more than seven (7) consecutive calendar days for each day the Executive Director has not been appointed;
   2. Seven hundred dollars ($700.00) per calendar day for failure to have a full-time acting or permanent Dental Director for more than seven (7) consecutive calendar days for each day the Dental Director has not been appointed.
   3. Two hundred fifty dollars ($250.00) per calendar day for each day per employee that is not licensed as required by applicable state and federal laws and/or regulations.

D. Excessive Reversals on Appeal
   Twenty-five thousand dollars ($25,000.00) for exceeding ten percent (10%) member appeals over a twelve month period (January-December or twelve months from the effective date of the Contract) which have been overturned in final appeal outcome for each occurrence over 10%; or for each occurrence in which the DBPM does not provide the dental services or requirements set forth in a final outcome of the administrative decision by LDH or the appeals decision of the State Fair Hearing.

E. Member Education Violations
   1. Whenever LDH determines that the DBPM, its agents, subcontractors, volunteers or providers has engaged in any unfair, deceptive, or prohibited member education practices in connection with proposing, offering, selling, soliciting, and providing any services, one or more of the remedial actions outlined this contract shall apply.
   2. Unfair, deceptive, or prohibited practices shall include, but are not limited to:

1) Failure to secure written approval before distributing member education materials;
2) Failure to meet time requirements for communication with new members;
3) Failure to provide interpretation services or make materials available in required languages;
4) Engaging in any of the prohibited member education practices detailed in this contract;
5) 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 DBPM potential enrollees or enrollees with respect to any services, provider, or the Medicaid Managed Care Program;
6) Representation that the DBPM or network provider offers any service, benefit, access to care, or choice which it does not have;
7) Representation that the DBPM or healthcare provider has any status, certification, qualification, sponsorship, affiliation, or licensure which it does not have;
8) Use of any information related to an eligible Medicaid beneficiary or any other 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:
   - Dental records information, and
   - Information which identifies the beneficiary or any member of his or her group as a beneficiary of any government sponsored or mandated health coverage program.
9) If LDH determines the DBPM has violated any of the outreach activities outlined in the Contract, the DBPM may be subject to remedial sanctions 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 LDH.

F. Remedial Action(s) for Member Education Violations

LDH shall notify the DBPM 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 DBPM must perform.

1. LDH may require the DBPM to recall the previously authorized material(s);
2. LDH may deduct the amount of capitation payment for members enrolled as a result of non-compliant practices from the next monthly capitation payment made to the DBPM and shall continue to deduct such payment until correction of the failure; and
3. LDH may require the DBPM to contact each member affected during by the compliance, in order to explain the nature of the non-compliance.

G. Cost Avoidance Requirements

Whenever LDH determines that the DBPM is not actively engaged in cost avoidance, the DBPM shall be subject to sanctions in an amount not less than three (3) times the amount that could have been cost avoided.

H. Failure to Provide Core Dental Benefits and Services

In the event that LDH determines that the DBPM failed to provide one or more core dental benefits and services, LDH shall direct the DBPM to provide such service. If the DBPM continues to refuse to provide the core dental benefit or service(s), LDH shall authorize the members to obtain the covered service from another source and shall notify the DBPM in writing that the DBPM shall be charged the actual amount of the cost of such service. In such event, the charges to the DBPM shall be obtained by LDH in the form of deductions of that amount

from the next monthly capitation payment made to the DBPM. With such deductions, LDH shall provide a list of the members from whom payments were deducted, the nature of the service(s) denied, and payments LDH made or will make to provide the medically necessary covered services.

I. Failure to Maintain an Adequate Network of Contract Providers

In the event that LDH determines that the DBPM 1) failed to maintain an adequate network of mandatory contract provider types as specified in the Provider Network Requirement Section of this contract, 2) did not comply with the requirement to make three documented attempts to contract with the provider, and 3) is required to pay for medically necessary services to a non-network provider, a monetary penalty of up to $10,000 per incident may be assessed.

J. Intermediate Sanctions

1. LDH shall notify the DBPM and CMS in writing of its intent to impose sanctions for violating the terms and conditions of the Contract or violation of federal Medicaid rules and regulations and will explain the process for the DBPM to employ the dispute resolution process as described in this contract. The following are non-exhaustive grounds for which intermediate sanctions may be imposed when the DBPM acts or fails to act. The DBPM:
   a) Fails substantially to provide medically necessary services that the DBPM is required to provide, under law or under the Contract, to a member covered under the Contract;
   b) Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Louisiana Medicaid DBP;
   c) Discriminates among members on the basis of their health status, need for healthcare services; race, color, national origin, sex, sexual orientation, gender identity, or disability. This includes termination of enrollment or refusal to reenroll a member or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future dental services.
   d) Misrepresents or falsifies information that it furnishes to CMS or to LDH;
   e) Misrepresents or falsifies information that it furnishes to a member, potential member, or a healthcare provider;
   f) Fails to comply with the requirements for Provider Incentive Plans, as set forth (for Medicare) in 42 CFR §422.208 and §422.210;
   g) Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by LDH or that contain false or materially misleading information; or
   h) 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.

2. The intermediate sanctions that LDH may impose upon the DBPM shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u-2) and 42 CFR §§438.700-730 and may include any of the following:
   a) Civil monetary penalties in the following specified amounts:
      i. A maximum of $25,000 for each determination of failure to provide services; misrepresentation or falsification of statements to members, potential members, or healthcare providers; failure to comply with Provider Incentive Plan requirements; or marketing violations;
      ii. A maximum of $100,000 for each determination of discrimination among members on the basis of their health status or need for services; or misrepresentation or falsification to CMS or LDH;
      iii. A maximum of $15,000 for each member LDH determines was discriminated against based on the member's health status or need for services (subject to the $100,000 limit above);

iv. A maximum of $25,000 or double the amount of the excess charges (whichever is greater), for charging premiums or charges in excess of the amounts permitted under the Louisiana Medicaid DBP Program. LDH shall return the amount of overcharge to the affected member(s);

b) Suspension of payment for members enrolled after the effective date of the sanction and until CMS or LDH is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

c) Additional sanctions allowed under state statutes or regulations that address areas of noncompliance described above.

3. The following factors will be considered in determining sanction(s) to be imposed:
   a) Seriousness of the offense(s);
   b) Patient quality of care issues;
   c) Failure to perform administrative functions;
   d) Extent of violations; history of prior violations; prior imposition of sanctions;
   e) Prior provision of provider education; provider willingness to obey program rules;
   f) Whether a lesser sanction will be sufficient to remedy the problem; and
   g) Actions taken or recommended by peer review groups or licensing boards.

K. Misconduct for Which Intermediate Sanctions May Be Imposed

LDH may impose sanctions against the DBPM if the agency finds any of the following non-exclusive actions/occurrences:

1. The DBPM has failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from LDH;
2. The DBPM has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to Public Law 95-142;
3. The DBPM or any of its owners, officers or directors has been convicted of a criminal offense relating to performance of the Contract with LDH or of fraudulent billing practices or of negligent practice resulting in death or injury to the DBPM's member;
4. The DBPM 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 U.S. Department of Health and Human Services;
5. The DBPM 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 LDH;
6. The DBPM has rebated or accepted a fee or portion of fee or charge for a patient referral;
7. The DBPM has failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments;
8. The DBPM has failed to keep or make available for inspection, audit or copying, such records regarding payments claimed for providing services;
9. The DBPM has failed to furnish any information requested by LDH regarding payments for providing goods or services;
10. The DBPM has made, or caused to be made, any false statement or representation of a material fact to LDH or CMS in connection with the administration of the Contract;
11. The DBPM has furnished goods or services to a member which at the sole discretion of LDH, and based on competent dental 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.

L. Notice to CMS

LDH will give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR §438.700 specifying the affected DBPM, the kind of sanction, and the reason for LDH's decision to lift a

sanction. Notice will be given no later than thirty (30) days after LDH imposes or lifts the sanction.

M. Federal Sanctions
Section 1903(m)(5)(A) and (B) of the Social Security Act vests the Secretary of the Department of Health and Human Services with the authority to deny Medicaid payments to a DBPM for members who enroll after the date on which the DBPM has been found to have committed one or more of the violations identified below. Therefore, whenever, and for so long as, federal payments are denied, LDH shall deduct the total amount of federal payments denied from the next monthly capitation payment made to the DBPM.
1. Substantial failure to provide required medically necessary items or services when the failure had adversely affected (or has substantial likelihood of adversely affecting) a member;
2. Discrimination among members with respect to enrollment, re-enrollment, or disenrollment on the basis of the member's health status or requirements for healthcare services;
3. Misrepresentation or falsification of certain information; or
4. Failure to comply with the requirements for Provider Incentive Plans as specified herein.

N. Sanction by CMS—Special Rules Regarding Denial of Payment
Payments provided under this Contract may 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.

O. Payment of Monetary Penalties
1. Any monetary penalties assessed by LDH that cannot be collected through withholding from future PMPM payments shall be due and payable to LDH within thirty (30) calendar days after the DBPM's receipt of the notice of monetary penalties. However, in the event an appeal by the DBPM results in a decision in favor of the DBPM, any such funds withheld by LDH will be returned to the DBPM.
2. LDH has the right to recovery of any amounts overpaid as the result of deceptive practices by the DBPM and/or its contractors, and may consider trebled damages, civil penalties, and/or other remedial measures.
3. A monetary sanction may be applied to all known affiliates, subsidiaries and parents of the DBPM, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the DBPM is affiliated where such conduct was accomplished within the course of his official duty or was effectuated by him with the knowledge or approval of such person.

J. Additional Terms and Conditions

1. The DBPM shall 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:
   a. Title 42, Code of Federal Regulations (CFR) Chapter IV, Subchapter C (Medical Assistance Programs);
   b. All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. §7401, *et seq.*) and 20 USC §6082(2) of the Pro-Children Act of 1994, as amended (P.L. 103-227);
   c. The Age Discrimination Act of 1975, as amended, 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;
   d. The Omnibus Budget Reconciliation Act of 1981, as amended, 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;

e. The Balanced Budget Act of 1997, as amended, P.L. 105-33 and the Balanced Budget Refinement Act of 1999, as amended, H.R. 3426;
f. All applicable standards, orders, or regulations issued pursuant to La.R.S. 49:1001 – 1021;
g. The Federal Drug Free Workplace Act of 1988 as implemented by 45 CFR Part 82;
h. Title IX of the Education Amendments of 1972 regarding education programs and activities; and
i. 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 Part 3).

2. **Assessment of Fees/Payment of Premium Taxes**
   a. The Contractor and LDH agree that LDH may elect to deduct any assessed fees from payments due or owing to the DBPM or direct the DBPM to make payment directly to LDH for any and all assessed fees. The choice is solely and strictly LDH's.
   b. The DBPM shall be responsible for payment of all premium taxes paid through the capitation payments by LDH to the Louisiana Department of Insurance according to the schedule established by LDH.

3. **Attorney's Fees**
   In the event LDH should prevail in any legal action arising out of the performance or non-performance of the Contract, the DBPM shall pay, in addition to any monetary penalties, all expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

4. **Confidentiality of Information**
   a. The DBPM shall comply with the HIPAA Privacy and Security Rules, with other applicable federal and state laws and regulations, and with the provisions of this Contract in its use and disclosure of dental records and any and all other health and enrollment information relating to members or potential members, which is provided to or obtained by or through the DBPM's performance under this Contract, whether verbal, written, electronic file, or otherwise, The DBPM 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. The HIPAA Business Associate Addendum (Attachment A) shall become a part of the Contract.

   b. All information as to personal facts and circumstances concerning members or potential members obtained by the DBPM shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of LDH or the member/potential member unless required by applicable state or federal law or otherwise permitted by the HIPAA Privacy Rule, 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.

5. **Conflict of Interest**
   The DBPM may not contract with Louisiana Medicaid unless such safeguards at least equal to federal safeguards (41 USC §423) are in place per state Medicaid

Director letter dated December 30, 1997 and 1932 (d)(3) of the Social Security Act addressing 1932 State Plan Amendment and the default enrollment process under the State Plan Amendment option.

6. **Contract Language Interpretation**
   The DBPM and LDH agree that in the event of a disagreement regarding, arising out of, or related to, Contract language interpretation, LDH's interpretation of the Contract language in dispute shall control and govern.

7. **Cooperation with Other Contractors**
   a. In the event that LDH has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder including but not limited to fiscal intermediary and actuary, the DBPM agrees to cooperate fully with such other contractors. The DBPM shall not commit any act that will interfere with the performance of work by any other contractor.
   b. The DBPM's failure to cooperate and comply with this provision, shall be sufficient grounds for LDH to halt all payments due or owing to the DBPM until it becomes compliant with this or any other contract provision. LDH's determination on the matter shall be conclusive and not subject to Appeal.

8. **Copyrights**
   If any copyrightable material is developed in the course of or under this Contract, LDH shall have a royalty free, non-exclusive, and irrevocable right to reproduce, publish, or otherwise use the work for LDH purposes.

9. **Corporation Requirements**
   If the DBPM is a corporation, the following requirements must be met prior to execution of the Contract:
   a. If a for-profit corporation whose stock is not publicly traded, the DBPM must file a Disclosure of Ownership form with the Louisiana Secretary of State.
   b. If the DBPM is a corporation not incorporated under the laws of the state of Louisiana, the DBPM must obtain a Certificate of Authority pursuant to R.S. 12:301-302 from the Louisiana Secretary of State.
   c. The DBPM must provide written assurance to LDH from the DBPM's legal counsel that the DBPM is not prohibited by its articles of incorporation, bylaws or the laws under which it is incorporated from performing the services required under the Contract.

10. **Debarment/Suspension/Exclusion**
    a. The DBPM agrees to comply with all applicable provisions of 42 CFR Part 376 (2009, as amended), pertaining to debarment and/or suspension. As a condition of enrollment, the DBPM 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 healthcare programs. To help make this determination, the DBPM may search the following websites: Office of Inspector General (OIG) List of Excluded Individuals/Entities) LEIE http://exclusions.oig.hhs.gov/search.aspx; the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.jsp and/or System for Award Management http://www.sam.gov.
    b. The DBPM shall conduct a search of the website monthly to capture exclusions and reinstatements that have occurred since the last search and any exclusion information discovered should be immediately reported to LDH. Any individual or entity that employs or subcontracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against providers who employ or enter into provider

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).

11. **Effect of Termination on DBPM's HIPAA Privacy Requirements**
    a. Upon termination of this Contract for any reason, the DBPM shall return or destroy all Protected Health Information received from LDH, or created or received by the DBPM on behalf of LDH. This provision shall also apply to Protected Health Information that is in the possession of subcontractors or agents of the DBPM. The DBPM shall not retain any copies of the Protected Health Information.
    b. In the event that the DBPM determines that returning or destroying the Protected Health Information is not feasible, the DBPM shall provide to LDH notification of the conditions that make return or destruction not feasible. Upon a mutual determination that return or destruction of Protected Health Information is not feasible, the DBPM shall extend the protections of the Contract to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction not feasible, for so long as the DBPM maintains such Protected Health Information.

12. **Emergency Management Plan**
    a. The DBPM shall submit an emergency management plan as part of the contract document execution process. The emergency management plan shall specify actions the DBPM shall conduct to ensure the ongoing provision of health services in an epidemic, disaster or manmade emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies. Revisions to the LDH approved emergency plan shall be submitted to LDH for approval no less than 30 days prior to implementation of requested changes. The DBPM shall submit an annual certification (from the date of the most recently approved plan) to LDH certifying that the emergency plan is unchanged from the previously approved plan.
    b. At a minimum, the plan should include the following:
        1) Educating members and providers regarding hurricane preparedness and evacuation planning;
        2) Providing a DBPM contact list (phone and email) for members and providers to contact to determine where healthcare services may be accessed/rendered;
        3) Use of EHR to provide healthcare providers access to member's health history and receive information of care provided during evacuation; and
        4) Emergency contracting with out-of-state healthcare providers to provide healthcare services to evacuated members.

13. **Employee Education about False Claims Recovery**
    If the DBPM receives annual Medicaid payments of at least $5,000,000, the DBPM must comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005.

14. **Employment of Personnel**
    a. In all hiring or employment made possible by or resulting from this Contract, the DBPM agrees that:
        1) There shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, or national origin; and
        2) Affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all state and federal laws applicable to employment of personnel.
        3) 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

DBPM further agrees to give public notice in conspicuous places available to employees and applicants for employment setting forth the provisions of this section. All solicitations or advertisements for employees shall state that all qualified applicants will receive consideration for employment without regard to handicap, age, race, color, religion, sex, or national origin.

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

15. **Entire Contract**
    a. This Contract, together with the exhibits and attachments specifically incorporated herein by reference, constitute the entire agreement between the parties with respect to the subject matter.
    b. The DBPM shall comply with all provisions of the Contract and shall act in good faith in the performance of the provisions of said Contract. The DBPM shall be bound by all applicable Department issued guides. The DBPM 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.
    c. The DBPM shall comply with all applicable LDH policies and procedures in effect throughout the duration of the Contract period.
    d. The DBPM shall comply with all applicable LDH provider manuals, rules, regulations, and guides.
    e. LDH, at its discretion, will issue correspondence to inform the DBPM of changes in Medicaid policies and procedures which may affect the Contract. Unless otherwise specified in the Medicaid correspondence, the DBPM will be given sixty (60) calendar days to implement such changes.

16. **Force Majeure**
    The DBPM and LDH may be excused from performance under this Contract for any period they may be prevented from performance by an Act of God; strike, war, civil disturbance or court order. The DBPM shall, however, be responsible for the development and implementation of an Emergency Management Plan.

17. **Hold Harmless**
    a. The DBPM shall indemnify, defend, protect, and hold harmless LDH and any of its officers, agents, and employees from:
        1) Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for the DBPM in connection with the performance of this Contract;
        2) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by DBPM, its agents, officers, employees, or subcontractors in the performance of this Contract;
        3) Any claims for damages or losses resulting to any person or firm injured or damaged by the DBPM, its agents, officers, employees, or subcontractors by DBPM's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Contract in a manner not authorized by the Contract or by federal or state regulations or statutes;
        4) Any failure of the DBPM, its agents, officers, employees, or subcontractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;
        5) Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of LDH in connection with the defense of claims for such injuries, losses, claims, or damages specified above; and

6) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against LDH or their agents, officers or employees, through the intentional conduct, negligence or omission of the DBPM, its agents, officers, employees or subcontractors.

b. In the event of circumstances not reasonably within the control of the DBPM or LDH, (*i.e.,* a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither the DBPM, LDH, or any subcontractor(s), will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered services. Notwithstanding, as long as this Contract remains in full force and effect, the DBPM shall be liable for the core dental benefits and services required to be provided or arranged for in accordance with this Contract.

c. LDH will provide prompt notice of any claim against it that is subject to indemnification by DBPM under this Contract. The DBPM may, at its sole option, assume the defense of any such claim. LDH may not settle any claim subject to indemnification hereunder without the advance written consent of DBPM, which shall not be unreasonably withheld.

18. **Hold Harmless as to the DBPM Members**

a. The DBPM 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, DBPM members, or persons acting on their behalf, for healthcare services which are rendered to such members by the DBPM and its subcontractors, and which are core dental benefits and services.

b. The DBPM further agrees that the DBP member shall not be held liable for payment for core dental benefits and services furnished under a provider contract, referral, or other arrangement, to the extent that those payments would be in excess of the amount that the member would owe if the DBPM provided the service directly. The DBPM agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by the DBPM and insolvency of the DBPM.

c. The DBPM further agrees that this provision shall be construed to be for the benefit of DBPM members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the DBPM and such members, or persons acting on their behalf.

19. **Homeland Security Considerations**

a. The DBPM shall perform the services to be provided under this Contract entirely within the boundaries of the United States. In addition, the DBPM 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.

b. If the DBPM performs services, or uses services, in violation of the foregoing paragraph, the DBPM shall be in material breach of this Contract and shall be liable to LDH for any costs, fees, damages, claims, or expenses it may incur. Additionally, the DBPM shall be required to hold harmless and indemnify LDH pursuant to the indemnification provisions of this Contract.

c. The prohibitions in this Section shall also apply to any and all agents and subcontractors used by the DBPM to perform any services under this Contract.

20. **Independent Capacity**

It is expressly agreed that the DBPM and any subcontractors and agents, officers, and employees of the DBPM or any subcontractors in the performance of this Contract shall act in an independent capacity and not as officers, agents, express or implied, or employees of LDH or the state of Louisiana. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the DBPM or any subcontractor and LDH and the State of Louisiana.

21. **Integration**
This Contract and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. The DBPM also agrees to be bound by the Contract and any rules or regulations that may be promulgated. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or 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.

22. **Interest**
Interest generated through investments made by the DBPM under this Contract shall be the property of the DBPM and shall be used at the DBPM's discretion.

23. **Interpretation Dispute Resolution Procedure**
    a. The DBPM may request in writing an interpretation of the issues relating to the Contract from the Medicaid Managed Care Director. In the event the DBPM disputes the interpretation by the Medicaid Managed Care Director, the DBPM shall submit a written reconsideration request to the Medicaid Director.
    b. The DBPM 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.
    c. The Medicaid Director shall reduce the decision to writing and provide a copy to the DBPM. The written decision of the Medicaid Director shall be final of LDH. The Medicaid Director will render his/her final decision based upon the written submission of the DBPM and the Medicaid Managed Care Director, unless, at the sole discretion of the Medicaid Director, the Medicaid Director allows an oral presentation by the DBPM and the Medicaid Managed Care Director or his/her designee. If such a presentation is allowed, the information presented will be considered in rendering the decision.
    d. Pending final determination of any dispute over a LDH decision, the DBPM shall proceed diligently with the performance of the Contract and in accordance with the direction of LDH.

24. **Loss of Federal Financial Participation (FFP)**
The DBPM hereby agrees to be liable for any loss of FFP suffered by LDH due to the DBPM'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. **Misuse of Symbols, Emblems, or Names in Reference to Medicaid**
No person or DBPM may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems the words "Louisiana Medicaid," or "Department of Health" or "Bureau of Health Services Financing," unless prior written approval is obtained from LDH. Specific written authorization from LDH is required to reproduce, reprint, or distribute any LDH form, application, or publication for a fee. State and local governments are exempt from this prohibition. A disclaimer that accompanies the inappropriate use of program or LDH terms does not provide a defense. Each piece of mail or information constitutes a violation.

26. **National Provider Identifier (NPI)**
The HIPAA Standard Unique Health Identifier regulations (45 CFR Part 162, Subparts A & D) require that all covered entities (healthcare clearinghouses, and those healthcare providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES).

27. **Non-Discrimination**
In accordance with 42 CFR §438.6 (d)(3) and (4), the DBPM shall not discriminate in the enrollment of Medicaid individuals into the DBPM. The DBPM agrees that no person, on the grounds of handicap, age, race, color, religion, sex, sexual orientation, gender identity, national origin, or basis of health status or need for healthcare services shall be excluded from participation in, or be denied benefits of the DBPM's program or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the DBPM. The DBPM shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts.

28. **Non-Waiver of Breach**
    a. The failure of LDH at any time to require performance by the DBPM of any provision of this Contract, or the continued payment of the DBPM by LDH, shall in no way affect the right of LDH to enforce any provision of this Contract; nor shall the waiver of any breach of any provision thereof be taken or held to be a waiver of any succeeding breach of such provision or as a waiver of the provision itself. No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract shall be waived except by the written agreement of the parties and approval of CMS, if applicable.
    b. 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.

29. **Offer of Gratuities**
By signing this Contract, the DBPM signifies that no member of, or a delegate of, Congress, nor any elected or appointed official or employee of the State of Louisiana, the Government Accountability Office, HHS, CMS, or any other federal agency has or shall benefit financially or materially from this Contract. This Contract may be terminated by LDH if it is determined that gratuities of any kind were offered to, or received by, any officials or employees from the state, its agents, or employees.

30. **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".

31. **Prohibited Payments**
Payment for the following shall not be made:
    - Non-emergency dental services provided by or under the direction of an excluded individual;
    - Any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; and
    - Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a state plan.

32. **Rate Adjustments**
    a. The LDH agreed upon monthly capitation rates shall be in effect during the period identified on the in their contract. Rates may be adjusted during the Contract period and subject to CMS review and approval.
    b. The DBPM and LDH both agree that the adjustments to the monthly capitation rate(s) required pursuant to this section shall occur only by written amendment to the Contract. Should either the DBPM or LDH refuse to accept the revised monthly capitation rate, the provisions for contract termination and turnover shall apply.

33. **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:

a. 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;
b. Records for real property and equipment acquired with federal funds shall be retained for six (6) years after final disposition;
c. When records are transferred to or maintained by LDH, the six (6) year retention requirement is not applicable to the recipient; and
d. Indirect cost rate proposals, cost allocations plans, etc., as specified in 45 CFR §74.53.

34. **Release of Records**

The DBPM shall release dental records upon request by members or authorized representative, as may be directed by authorized personnel of LDH, appropriate agencies of the State of Louisiana, or the United States Government and subject to reasonable charges. Release of dental records shall be consistent with the provisions of confidentiality as expressed in this Contract. The ownership and procedure for release of dental records shall be controlled by Louisiana law (including but not limited to LSA-R.S. 40:1165.1, LSA-R.S.. 13:3734, and La.C.Ev. Art. 510) and 45 CFR Parts 160 and 164 (HIPAA Privacy Rule) and shall be subject to reasonable charges. The DBPM shall not charge LDH/BHSF or its designated agent for any copies requested.

35. **Reporting Changes**

The DBPM shall immediately notify LDH of any of the following:

- Change in business address, telephone number, facsimile number, and email 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 email address;
- Change in incorporation status;
- Change in federal employee identification number or federal tax identification number; or
- Change in DBPM litigation history, current litigation, audits and other government investigations both in Louisiana and in other states.

36. **Safeguarding Information**

The DBPM 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 DBPM's written safeguards shall:

- Be comparable to those imposed upon the LDH by 42 CFR Part 431, Subpart F and La R.S. 46:56;
- State that the DBPM will identify and comply with any stricter state or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;
- 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.

37. **Safety Precautions**
LDH assumes no responsibility with respect to accidents, illnesses or claims arising out of any activity performed under this Contract. The DBPM shall take necessary steps to ensure the protection of its members, itself, and its personnel. The DBPM agrees to comply with all applicable local, state, and federal occupational and safety acts, rules, and regulations.

38. **Software Reporting Requirement**
All reports submitted to LDH by the DBPM must be in format accessible and modifiable by the standard Microsoft Office Suite of products, Version 2003 or later, or in a format accepted and approved by LDH.

39. **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, LDH may terminate the Contract without penalty. This notification will be made in writing. Availability of funds shall be determined solely by LDH.

40. **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.

41. **Titles**
All titles used herein are for the purpose of clarification and shall not be construed to infer a contractual construction of language.

42. **Use of Data**
LDH shall have unlimited rights to use, disclose, or duplicate, for any purpose, all information and data developed, derived, documented, or furnished by the DBPM resulting from this Contract.

43. **Waiver**
The waiver by LDH of any breach of any provision contained in this Contract shall not be deemed to be a waiver of such provision on any subsequent breach of the same or any other provision contained in this Contract and shall not establish a course of performance between the parties contradictory to the terms hereof.

44. **Warranty of Removal of Conflict of Interest**
The DBPM shall warrant that it, its officers, and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services hereunder. The DBPM shall periodically inquire of its officers and employees concerning such conflicts, and shall inform LDH promptly of any potential conflict. The DBPM shall warrant that it shall remove any conflict of interest prior to signing the Contract.

45. **CMS Approval**
The Centers for Medicare and Medicaid Services (CMS) Regional Office must approve the contract. If CMS does not approve the Contract entered into under the terms and conditions described herein, the contract shall be considered null and void.

46. **Public Records Request**
    a. The Contractor shall provide LDH with the name of the individual who will serve as the Contractor's point of contact for handling public records' requests. If this point of contact changes at any time during the contract term, the Contractor shall provide LDH with the updated point of contact within one business day.

    b. If LDH receives a request pursuant to the Louisiana Public Records Act for records that are in the custody of the Contractor, the Contractor shall provide

all records to LDH that the Department, in its sole discretion, determines are related to the services performed by the Contractor under this contract that are responsive to the request, pursuant to the timeline and in the requested format established by LDH.

c. If the Contractor receives the public records' request directly, the Contractor shall forward the request via email to the LDH Section Chief of Program Operations and Compliance within one business day of receipt. Thereafter, the Contractor shall provide all records to LDH that the Department determines, in its sole discretion, are related to the services performed by the Contractor under this contract that are responsive to the request, pursuant to the timeline and in the requested format established by LDH.

II. Glossary

Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in payment for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes enrollee practices that result in unnecessary cost to the Medicaid program.
Adjudicate	To deny or pay a clean claim.
Advance Directive	A written instruction, such as a living will or durable power of attorney for healthcare, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of healthcare when the individual is incapacitated.
Adverse Benefit Determination	The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service, the failure to provide services in a timely manner (as defined by LDH), and the failure of the DBPM to act within the timeframes for the resolution of grievances and appeals; and in a rural area with only one DBPM, the denial of a enrollee's right to obtain services outside the provider network.
Affiliate	Any individual or entity that meets any of the following criteria: • in which the DBPM owns or holds more than a five percent (5%) interest (either directly, or through one (1) or more intermediaries); • any parent entity or subsidiary entity of the DBPM regardless of the organizational structure of the entity; • any entity that has a common parent with the DBPM (either directly, or through one (1) or more intermediaries); • any entity that directly, or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, the DBPM; or • any entity that would be considered to be an affiliate by any Securities and Exchange Commission (SEC) or Internal Revenue Service (IRS) regulation, Federal Acquisition Regulations (FAR), or by another applicable regulatory body.
Agency	Any department, commission, council, board, office, bureau, committee, institution, agency, government, corporation, or other establishment of the executive branch of this State authorized to participate in any contract resulting from this solicitation.
Agent	An entity that contracts with LDH to perform administrative functions, including but not limited to fiscal intermediary activities, outreach, eligibility, and enrollment activities, systems and technical support, etc.
Appeal	A request for a review of an action.

Appeal Procedure	A formal process whereby an enrollee has the right to contest an adverse benefit determination by the DBPM.
Beneficiary	An individual who is eligible for Louisiana Medicaid.
Bureau of Health Services Financing (BHSF)	The agency within the Louisiana Department of Health, Office of Management and Finance that has been designated as Louisiana's single state Medicaid agency to administer the Medicaid and CHIP programs.
Business Continuity Plan (BCP)	A plan that provides for a quick and smooth restoration of MIS operations after a disruptive event. BCP includes business impact analysis, BCP development, testing, awareness, training, and maintenance. This is a day-to-day plan.
Business Day	Traditional workdays, including Monday, Tuesday, Wednesday, Thursday and Friday. State holidays are excluded and traditional work hours are 8:00 a.m. – 5:00 p.m., unless the context clearly indicates otherwise.
Calendar Day	All seven (7) days of the week. Unless otherwise specified, the term "days" in the contract refers to calendar days.
Can	Denotes a preference but not a mandatory requirement.
Capitation Payment	A monthly payment, fixed in advance, that LDH makes to the DBPM for each enrollee covered under the contract for the provision of covered dental benefits and services and assigned to the DBPM. This payment is made regardless of whether the enrollee receives covered dental benefits and services during the period covered by the payment.
Claim	1) A bill for services; 2) a line item of service; or 3) all services for one enrollee within a bill.
Clean Claim	A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
Community Norms	Services and accessibility to services that enrollees are accustomed to in their geographic area.
Contract	Written agreement between LDH and the DBPM; comprised of the RFP, contract, and any addenda, appendices, attachments, or amendments thereto.
Contract Term	The period during which the contract is in effect.
Contractor	Any person having a contract with a governmental body; the selected Proposer.
Convicted	A judgment of conviction entered by a federal, state or local court, including a plea of guilty or nolo contendere, regardless of whether an appeal from that judgment is pending.
Copayment	Any cost sharing payment for which the Medicaid DBPM enrollee is responsible.
Covered Dental Benefits and Services	A schedule of healthcare benefits and services required to be provided by the DBPM to Medicaid enrollees as specified under the terms and conditions of this RFP and contract and the Louisiana Medicaid State Plan.
Corrective Action Plan (CAP)	A plan developed by the DBPM that is designed to ameliorate an identified deficiency and prevent reoccurrence of that deficiency. The CAP outlines all steps/actions and timeframe necessary to address and resolve the deficiency. Use of the CAP will be at the discretion of LDH.
Cost Avoidance	A method of paying claims in which the provider is not reimbursed until the provider has demonstrated that all available health insurance has been exhausted.
Cultural Competency	A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance of and respect for cultural differences and similarities within, among and between groups and

	the sensitivity to how these differences influence relationships with enrollees. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse enrollee needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.
Current Dental Terminology (CDT)	A code set with descriptive terms developed and updated by the American Dental Association (ADA) for reporting dental services and procedures to dental benefits plans. DHHS designated the CDT code set as the national terminology for reporting dental services.
Current Procedural Terminology (CPT®)	Current version is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. DHHS designated the CPT code set as the national coding standard for physician and other healthcare professional services and procedures under HIPAA.
Dental Benefit Program Systems Companion Guide	A supplement to the contract that outlines the formatting and reporting requirements concerning encounter data, interfaces between the FI and the DBPM, and Enrollment Broker and the DBPM.
Deliverable	Any requirement of the contract.
Denied Claim	A claim for which no payment is made to the network provider by the DBPM for any of several reasons, including but not limited to, the claim is for non-covered services, an ineligible provider or beneficiary, or is a duplicate of another transaction, or has failed to pass a significant requirement in the claims processing system.
Dental Director	The licensed dentist designated by the DBPM to exercise general supervision over the provision of covered dental benefits and services by the DBPM.
Documented Attempt	A bona fide, or good faith, attempt, in writing, by the DBPM to contract with a provider, made on or after the date the DBPM signs the contract with LDH. Such attempts may include written correspondence that outlines contract negotiations between the parties, including rate and contract terms disclosure. If, within ten (10) calendar days, the potential network provider rejects the request or fails to respond either verbally or in writing, the DBPM may consider the request for inclusion in the DBPM's network denied by the provider. This shall constitute one attempt.
Duplicate Claim	A claim that is either a total or a partial duplicate of services previously paid.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A federally required Medicaid benefit for individuals under the age of twenty-one (21) years that expands coverage for children and adolescents beyond adult limits to ensure availability of 1) screening and diagnostic services to determine physical or mental defects and 2) healthcare, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered. EPSDT requirements help to ensure access to all medically necessary health services within the federal definition of "medical assistance".
Eligibility Determination	The process by which an individual may be determined eligible for Medicaid or CHIP.
Eligible	An individual determined eligible for assistance in accordance with the Medicaid State Plan(s) under Title XIX (Medicaid) or Title XXI (CHIP) of the Social Security Act.
Emergency Dental Condition	A dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of dentistry and medicine, could reasonably expect the absence of immediate dental attention to result in the following: • Placing the health of the individual in serious jeopardy.

	• Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. A dental or oral condition that requires immediate services for relief of symptoms and stabilization of the condition; such conditions include severe pain; hemorrhage; acute infection; traumatic injury to the teeth and surrounding tissue; or unusual swelling of the face or gums.
Emergency Dental Services	Those services necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structures (periodontal membrane, gingival, alveolar bone), jaws, and tissue of the oral cavity.
Encounter	A distinct set of healthcare services provided to a Medicaid enrollee enrolled with the DBPM on the dates that the services were delivered.
Encounter Data	Healthcare encounter data include: (i) All data captured during the course of a single healthcare encounter that specify the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the enrollee receiving services during the encounter; (ii) The identification of the enrollee receiving and the provider(s) delivering the healthcare services during the single encounter; and, (iii) A unique, i.e. unduplicated, identifier for the single encounter.
Encounter Data Adjustment	Adjustments to encounter data that are allowable under the Medicaid Management Information System (MMIS) for HCFA 1500, UB 92, and NCPDP version 3.2 claim forms as specified in the Dental Benefit Program Systems Companion Guide.
Enrollee	A Medicaid beneficiary who is currently enrolled in the dental benefit plan manager. For marketing and education materials, or other informational materials provided to the enrollee, the term “member” may be used.
Enrollment	The process conducted by the DBPM or enrollment broker by which an eligible Medicaid beneficiary becomes an enrollee with the DBPM.
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.
Federal Financial Participation (FFP)	This is also known as federal match; the percentage of federal matching dollars available to a state to provide Medicaid and CHIP services. The Federal Medical Assistance Percentage (FMAP) is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.
Federally Qualified Health Center (FQHC)	An entity that receives a grant under Section 330 of the Public Health Service Act, as amended (Also see Section 1905(1)(2)(B) of the Social Security Act) to provide primary healthcare and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.
Fee-for-Service (FFS)	A method of provider payment based on payments for specific services rendered.
Fiscal Intermediary (FI)	LDH’s designee or agent responsible for an array of administrative support services including MMIS system development and maintenance, claims processing, pharmacy support services, provider enrollment and support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support.

Fraud	As relates to Medicaid Program Integrity, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain payment or certification; or claiming payment for services which were never delivered or received.
Full Time	Forty (40) hours per week.
Geocoding	Refers to the process in which implicit geographic data is converted into explicit or map-form images.
Geomapping	The process of finding associated geographic coordinates (often expressed as latitude and longitude) from other geographic data, such as street addresses, or zip codes (postal codes). With geographic coordinates, the features can be mapped and entered into Geographic Information Systems, or the coordinates can be embedded into media.
Grievance	An expression of enrollee dissatisfaction about any matter other than an adverse benefit determination. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.
HIPAA Privacy Rule	Health Insurance Portability and Accountability Act (HIPAA) federal standards for the privacy of individually identifiable health information, found at 45 CFR Part 164, Subpart E.
HIPAA Security Rule	Health Insurance Portability and Accountability Act (HIPAA) federal standards for the security of individually identifiable health information, found at 45 CFR Part 164, Subpart C.
ICD-10-CM codes	International Classification of Diseases, 10th Revision, Clinical Modification codes represent a uniform, international classification system of coding disease and injury diagnoses. This coding system arranges diseases and injuries into code categories according to established criteria.
Immediate	Without delay, but not more than twenty-four (24) hours.
Indian	Any individual defined at 25 USC §1603(13), §1603(28), or §1679(a), or who has been determined eligible as an Indian, under 42 CFR §136.12. This means the individual: • Is a enrollee of a Federally recognized Indian tribe; • Resides in an urban center and meets one or more of the following four criteria: o Is a enrollee of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such enrollee; o Is an Eskimo or Aleut or other Alaska Native; o Is considered by the Secretary of the Interior to be an Indian for any purpose; or o Is determined to be an Indian under regulations issued by the Secretary; • Is considered by the Secretary of the Interior to be an Indian for any purpose; or • Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health

	care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.
Indian Health Care Provider (IHCP)	A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. §1603).
Indian Managed Care Entity (IMCE)	An MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.
Information Systems (IS)	A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.
Information Systems Capabilities Assessment (ISCA)	Process to specify the desired capabilities of the DBPM's information system and to pose standard questions to be used to assess the strength of the DBPM with respect to these capabilities. The process will determine the extent to which the DBPM can produce valid encounter data, performances measures, and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its enrollees.
Louisiana Medicaid State Plan	The binding written agreement between Louisiana's Department of Health through LDH and CMS which describes how the Medicaid program is administered and determines the services for which LDH will receive federal financial participation.
Major Subcontract	Any contract, subcontract, or agreement between the DBPM and another entity that meets any of the following criteria: • the other entity is an affiliate of the DBPM; • the subcontract is considered by LDH 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 call lines (including dental consultation); or o any other subcontract that is, or is reasonably expected to be, more than one-hundred thousand dollars ($100,000) per year. Any subcontracts between the DBPM and a single entity that are split into separate agreements (e.g. by time period) will be consolidated for the purpose of this definition. 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.
Material Change	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 DBPM's complaint and grievance

	procedures; healthcare delivery systems, services, changes to expanded services; benefits; geographic service area; enrollment of a new population; procedures for obtaining access to or approval for healthcare services; any and all policies and procedures that required LDH approval prior to implementation; and the DBPM's capacity to meet minimum enrollment levels. LDH shall make the final determination as to whether a change is material.
May and Can	The terms "may" and "can" denote an advisory or permissible action.
Medicaid	A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act Amendment. Medicaid offers federal matching funds to states for costs incurred in paying healthcare providers for serving covered individuals.
Medicaid Management Information System (MMIS)	Mechanized claims processing and information retrieval system which all state Medicaid programs are required to have and which must be approved by the Secretary of LDH. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid providers and enrollees.
Medical Loss Ratio (MLR)	The percentage of PMPM payments received by the DBPM from LDH used to pay medical claims from providers and approved quality improvement and IT costs.
Medical Record	A single complete record kept at the site of the enrollee's treatment(s), which documents, medical or allied goods and services, including, but not limited to, outpatient and emergency medical healthcare services whether provided by the DBPM, its provider agreement, or any out-of-network providers. The records may be electronic, paper, magnetic material, film or other media. In order to qualify as a basis for payment, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media.
Medically Necessary Services	Are defined as those health care services that are in accordance with generally accepted evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. • to be considered medically necessary, services must be: o 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 o those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient. • any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. • Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary. • The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing services at his discretion on a case-by-case basis.
Medicare	The federal medical assistance program in the United States authorized in 1965 by Title XVIII of the Social Security Act, to

	address the medical needs of U.S. citizens sixty-five (65) years of age and older and some people with disabilities under age sixty-five (65)
Member	As it relates to this RFP, refers to a Medicaid enrollee. For marketing and education materials, or other informational materials provided to the enrollee, the term "member" may be used.
Member Month	A month of coverage for a Medicaid beneficiary who is enrolled in the DBPM.
Must	The term "must" denotes mandatory requirements.
Network	As utilized in the RFP, "network" may be defined as a group of participating providers linked through provider agreements or Contracts with the DBPM to supply a range of dental services. Also called a provider network.
Network Adequacy	A network of dental providers for the DBPM that is sufficient in numbers and types of providers and facilities to ensure that all services are accessible to enrollees without unreasonable delay. Adequacy is determined by a number of factors, including but not limited to, provider patient ratios; geographic accessibility and travel distance; waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments and hours of provider operations.
Non-Covered Services	Services not covered under the Title XIX Louisiana State Medicaid Plan.
Non-Emergency	A condition not requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structures (periodontal membrane, gingival, alveolar bone), jaws, and tissue of the oral cavity.
Original Signature	Denotes that a document must be signed in ink.
Out-of-Network Provider	An appropriately licensed individual, facility, agency, institution, organization or other entity that has not entered into a contract with the DBPM for the delivery of covered services to the DBPM's enrollees.
Ownership Interest	The possession of stock, equity in the capital, or any interest in the profits of the DBPM.
Performance Improvement Projects (PIP)	Projects to improve specific quality performance measures through ongoing measurements and interventions that result in significant improvement, sustained over time, with favorable effect on health outcomes and enrollee satisfaction.
Performance Measures	Specific operationally defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement related important dimensions of care and service.
Per Member Per Month (PMPM)	The per-member, per-month rate of payment paid to the DBPM by LDH for the provision of dental services to Dental Benefit Program enrollees. The PMPM shall be based on the total number of members included on a monthly reconciliation file.
Potential Enrollee	A Medicaid beneficiary who is subject to mandatory enrollment or who may voluntarily elect to enroll in a DBPM, but is not yet an enrollee of a specific DBPM.
Prepaid Ambulatory Health Plan (PAHP)	Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State Plan payment rates; does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.
Preventive Care	Dental care-related procedures or treatments that are meant to preserve healthy teeth and gums and to prevent dental caries and oral disease.

Primary Dental Provider (PDP)	A provider of primary dental services.
Primary Dental Services	Dental services and laboratory services customarily furnished by or through a primary dental provider for evaluation, diagnosis, prevention, and treatment of diseases, disorders, or conditions of the oral cavity, maxillofacial areas, or the adjacent and associated structures through direct service to the enrollee when possible, or through appropriate referral to specialists and/or ancillary providers.
Prior Authorization	The process of determining medical necessity for specific services before they are rendered.
Protected Health Information (PHI)	Individually identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Provider Agreement	An agreement between the DBPM and a provider of services to furnish covered dental benefits and services to enrollees for the DBPM specifically related to fulfilling the DBPM's obligations under the terms of this RFP.
Provider Appeal	The formal mechanism that allows a provider the right to appeal a DBPM final decision.
Provider-Beneficiary Relationship	An existing provider-beneficiary relationship is one in which the provider was a main source of Medicaid services for the beneficiary during the previous year. This may be established through state records of previous enrollment, encounter data, or through contact with the beneficiary.
Provider Complaint	A verbal or written expression by a provider which indicates dissatisfaction or dispute with DBPM policy, procedure, claims processing and/or payment, or any aspect of DBPM functions.
Provider Directory	A listing of dental service providers under contract with the DBPM that is prepared by the DBPM as a reference tool to assist enrollees in locating providers that are available to provide services.
Prudent Layperson	Person who possesses an average knowledge of health and medicine.
Quality Assessment and Performance Improvement Plan (QAPI Plan)	A written plan, required of the DBPM, detailing quality management and committee structure, performance measures, monitoring and evaluation process and improvement activities measures that rely upon quality monitoring implemented to improve healthcare outcomes for enrollees.
Quality Management (QM)	The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge.
Readiness Review	Assessment prior to implementation of the DBPM's ability to fulfill the RFP requirements. Such review may include but not be limited to review of proper licensure; operational protocols, review of DBPM standards; and review of systems. The review may be done as a desk review, on-site review, or combination of both and may include interviews with pertinent personnel so that LDH can make an informed assessment of the DBPM's ability and readiness to render services.
Referral	Dental services provided to the Dental Benefit Program enrollee when approved by the DBPM, including, but not limited to in-network specialty care and out-of-network services which are covered under the Louisiana Medicaid State Plan.
Reinsurance	Insurance the DBPM purchases to protect itself against part or all of the losses incurred in the process of honoring the claims of enrollees; also referred to as "stop loss" insurance coverage.

Remittance Advice	An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only.
Representative	Any person who has been delegated the authority to obligate or act on behalf of another. Also known as the authorized representative or AR.
Reprocessing (Claims)	Upon determination of the need to correct the outcome of one or more claims processing transactions, the subsequent attempt to process a single claim or batch of claims.
Responsible Party	An individual, often the head of household, who is authorized to make decisions and act on behalf of the Medicaid enrollee. This is the same individual that completes and signs the Medicaid application on behalf of a covered individual, agreeing to the rights and responsibilities associated with Medicaid coverage.
Risk	The chance or possibility of loss. The enrollee is at risk only for pharmacy copayments as allowed in the Medicaid State Plan and the cost of non-covered services.
Rural Area	Any parish that meets the federal Office of Management and Budget definition of rural.
Rural Health Clinic (RHC)	A clinic located in an area that has a healthcare provider shortage and is certified to receive special Medicare and Medicaid payment rates. RHCs provide primary healthcare and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services. RHCs must be reimbursed by the DBPM using prospective payment system (PPS) methodology.
Second Opinion	Subsequent to an initial medical opinion, an opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.
Secure File Transfer Protocol (SFTP)	Software protocol for transferring data files from one computer to another with added encryption.
Service Authorization	A utilization management activity that includes prior, concurrent, or post review of a service by a qualified health professional to authorize, partially deny, or deny in whole the payment of a service, including a service requested by the DBPM enrollee. Service authorization activities consistently apply review criteria.
Shall and Will	The terms “shall” and “will” denote mandatory requirements.
Should	The term “should” denotes a desirable action.
Significant	As utilized in this RFP, except where specifically defined, shall mean important in effect or meaning.
Social Security Act	The Social Security Act of 1935 (42 U.S.C.A. §301 et seq.) as amended which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI).
Solvency	The minimum standard of financial health for the DBPM where assets exceed liabilities and timely payment requirements can be met.
Span of Control	Information systems and telecommunications capabilities that the DBPM itself operates or for which it is otherwise legally responsible according to the terms and conditions with LDH. The span of control also includes systems and telecommunications capabilities outsourced by the DBPM.
Specialty Dental Services	A dentist, whose practice is limited to a particular branch of dentistry or oral surgery, including one who, by virtue of advanced training is certified by a specialty board as being qualified to so limit his practice.
Stratification	The process of partitioning data into distinct or non-overlapping groups.
Subcontractor	A person, agency or organization with which the DBPM has subcontracted or delegated some of its management functions or

	other contractual responsibilities to provide covered services to its enrollees.
Subsidiary	An affiliate that is owned or controlled by the Contractor, either directly or indirectly through one (1) or more intermediaries.
System Unavailability	Measured within the DBPM's information system span of control. A system is considered not available when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "enter" or other function key.
Third Party Liability (TPL)	The legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State Plan.
Timely	Existing or taking place within the designated period; within the time required by statue or rules and regulations, contract terms, or policy requirements.
Title XIX	Title of the Social Security Act of 1935, as amended, that encompasses and governs the Medicaid Program.
Title XXI	Title of the Social Security Act of 1935, as amended, that encompasses and governs the Children's Health Insurance Program (CHIP).
TTY/TTD	Telephone Typewriter and Telecommunication Device for the Deaf, which allows for interpreter capability for deaf callers.
Turnover Phase	All activities the DBPM is required to perform in conjunction with the end of the contract.
Turnover Plan	Written plan developed by the DBPM, approved by LDH, to be employed during the turnover phase.
Urban Area	Any parish that meets the federal Office of Planning and Budget definition of urban.
Urgent Care	Medical care provided for a condition that without timely treatment, could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily function, or cause the development of a chronic illness or need for a more complex treatment. Urgent care requires timely face-to-face medical attention within twenty-four (24) hours of enrollee notification of the existence of an urgent condition.
Utilization	The rate patterns of service usage or types of service occurring within a specified period of time.
Utilization Management (UM)	The process to evaluate the medical necessity, appropriateness, and efficiency of the use of dental services, procedures, and facilities. UM is inclusive of utilization review and service authorization.
Utilization Review (UR)	Evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of covered dental benefits and services, procedures or settings, and ambulatory review, prospective review, second opinions, care management, discharge planning, or retrospective review.
Validation	The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias and in accord with standards for data collection and analysis.
Virtual Private Network	A network that extends a private network across a public network such as the Internet.
Waiting Time(s)	Time spent both in the lobby and in the examination room prior to being seen by a provider.
Waiver	Medicaid Section 1915(c) Home and Community Based Services (HCBS) programs which in Louisiana are New Opportunities Waiver (NOW), Children's Choice, Adult Day Healthcare (ADHC), Community Choices, Supports Waiver, Residential Options Waiver (ROW), and any other 1915(c) waiver that may be implemented.
Week	The seven-day week, Monday through Sunday.
Will	Denotes a mandatory requirement.
Willful	Conscious or intentional but not necessarily malicious act.

III. CONTRACTUAL INFORMATION

A. Performance Bond

1. The DBPM shall be required to establish and maintain a performance bond for as long as the DBPM has Contract-related liabilities of fifty thousand dollars ($50,000) or more outstanding, or fifteen (15) months following the termination date of this contract, whichever is later, to guarantee: (1) payment of the Contractor's obligations to LDH and (2) performance by the DBPM of its obligations under this contract (42 CFR §438.116).
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.
3. The bond amount shall be equal to one hundred percent (100%) of the total capitation payment paid to the Contractor in the first (1st) month of the contract year. The bond amount shall be reevaluated and adjusted annually. The bond must be submitted to LDH by the end of the second (2nd) month of each contract year.
4. All bonds submitted to LDH must be original and have the raised engraved seal on the bond and on the Power of Attorney page. The DBPM must retain a photocopy of the bond.
5. Any performance bond furnished shall be written by a surety or insurance company currently on the U.S. Department of the Treasury Financial Management Service list of approved bonding companies which is published annually in the Federal Register, or by a Louisiana domiciled insurance company with at least an A-rating in the latest printing of the A.M. Best's Key Rating Guide to write individual bonds up to ten (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.

Attachment C
LaGov# 2000412922

CMS Requirement for MARS-E 2.0

1. Each party to this agreement shall ensure appropriate protections of shared Personally Identifiable Information ("PII"), in accordance with 45 CFR §155.260.

2. Each party to this agreement shall ensure that its system is operated in compliance with the Centers for Medicare and Medicaid Services' ("CMS") latest version of the *Minimum Acceptable Risk Standards for Exchanges (MARS-E)* Document Suite, currently MARS-E version 2.0.

    a. Multi-factor authentication is a CMS requirement for all remote users, privileged accounts, and non-privileged accounts. In this context, "remote user" refers to staff accessing the network from offsite, normally with a client VPN ("Virtual Private Network") with the ability to access CM, specifically Medicaid, data.

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

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Ms. Pam Diez
Deputy Medicaid Director/Chief Financial Officer
Louisiana Department of Health
Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70821-0629

June 28, 2019

Subject: Louisiana Medicaid Dental Benefit Program Capitation Rate Certification for the Period July 1, 2019 through June 30, 2020

Dear Ms. Diez:

In partnership with the State of Louisiana (State), Mercer Government Human Services Consulting (Mercer) has developed statewide actuarially sound[1] capitation rates for the Louisiana Medicaid Dental Benefit Program (DBP). These rates are applicable for the contract period July 1, 2019 through June 30, 2020 (State Fiscal Year, or SFY, 2020).

This document presents an overview of the rate development for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS). This rate development process was based on managed care encounter data and financial data provided by Managed Care of North America (MCNA) Dental, the current DBP contractor. It resulted in the development of a range of actuarially sound rates for each rate cell. The final capitation rates are summarized in Table 1 and represent payment in full for the covered services.

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[1] Actuarially Sound/Actuarial Soundness — Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes.

Reference: http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf.

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DENTAL CAPITATION RATES

The proposed actuarially sound rates for the DBP are shown in Table 1.

TABLE 1: DENTAL CAPITATION RATES

JULY 1, 2019 THROUGH JUNE 30, 2020	
Rate Cell Description	**Monthly Capitation Rate Per Member**
LaCHIP Affordable Plan	$20.95
Medicaid Child/CHIP	$17.34
Medicaid Adult	$1.41
Medicaid Expansion Child	$16.70
Medicaid Expansion Adult	$0.97

MANAGED CARE RATE DEVELOPMENT METHODOLOGY

Overview

Effective July 1, 2014, Louisiana implemented a managed DBP for Louisiana Children's Health Insurance Program (LaCHIP) Affordable Plan, Medicaid Children (including the primary LaCHIP program), and Medicaid Adult populations. The DBP covers preventive dental services for eligible members younger than age 21 and adult denture benefits for eligible members at age 21 and above. The managed DBP is expected to efficiently manage service costs and utilization, improve access to essential specialty dental services and increase outreach and education to promote healthy dental behavior.

The capitation rates provided above have been developed consistent with guidance provided in the CMS Medicaid Managed Care Rate Development Guide. These actuarially sound dental capitation rates are based upon the State Plan-covered services only. Base period dental claims data were analyzed, completed, and trended. Adjustments were applied, as appropriate, to reflect programmatic changes to the State Plan that affect the base period data and the contract period. A Prepaid Ambulatory Health Plan (PAHP) administrative load assumption was developed and included. Each of these rating elements is discussed in detail below.

Covered Populations

In general, the DBP covers most Medicaid eligible, LaCHIP and the LaCHIP Affordable Plan populations including full dual eligibles. The LaCHIP population was included in the Medicaid Children category for the dental capitation rates.

Effective July 1, 2016, Louisiana expanded Medicaid coverage under the Affordable Care Act (ACA). The Expansion population was also included in the DBP covered populations.

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The DBP non-covered populations are shown in Appendix A.

Rate Cell Structure

For the period of July 1, 2019 through June 30, 2020 rate setting, Mercer established five distinct rate cells for the DBP program.

TABLE 2: RATE CELL STRUCTURE

RATE CELL	PROGRAM	AGE RANGE
LaCHIP Affordable Plan	Non-Expansion	0–20
Medicaid Child/CHIP	Non-Expansion	0–20
Medicaid Adult	Non-Expansion	21 and above
Medicaid Expansion Child	Expansion	19–20
Medicaid Expansion Adult	Expansion	21–64

BASE DATA

For SFY 2020 rate setting, Mercer relied on Louisiana Medicaid eligibility and enrollment data and managed care encounter data from state fiscal years SFYs 2017 and 2018.

Mercer combined SFYs 2017 and 2018 data to form the base data for the Medicaid Non-Expansion population. For the Medicaid Expansion population, Mercer used the most recent year of experience available (i.e., SFY 2018) as base data.

Mercer reviewed the data provided by the State for consistency and reasonableness and determined the data is appropriate for the purpose of setting capitation rates for the DBP. Mercer confirmed the services included in this historical experience are State Plan-covered services only.

Retroactive Eligibility

Per the State, membership and claims incurred for covered services rendered prior to enrollment and during any retroactive period up to 12 months of eligibility are covered in the DBP. These claims and eligibility are included in the base data.

Institution of Mental Diseases (IMDs)

The base data was adjusted to remove member months and dental claims associated with enrollees aged 21–64 who stayed in an IMD for more than 15 days. The adjustment reduced the adult base member months from 3,692,665 to 3,692,290 for SFY 2017 and from 8,641,394 to 8,640,781 for SFY 2018.

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The base data had no dental claims associated with enrollees ages 21–64 who stayed in an IMD for more than 15 days.

Under-Reporting Adjustment

The under-reporting adjustment was developed by comparing encounter data from the Medicaid Management Information System to financial information provided by MCNA. The adjustment was based on detailed quarterly reported financial data provided by MCNA. The year-end financial report is reviewed by the managed care organizations (MCOs) auditors using agreed upon procedures. The audit report accounts for any changes or recommendations recommended by the auditor. Additionally, the financial data is compared to the MCO's annual statutory filing using standards from the National Association of Insurance Commissioners, commonly known as the "Orange Blank," to check for accuracy and completeness.

The adjustment was developed and applied by Child versus Adult. The Child grouping combines Medicaid Child/CHIP, Medicaid Expansion Child and LaCHIP Affordable Plan. The Adult grouping combines Medicaid Adult and Medicaid Expansion Adult. For SFY 2017, the adjustment resulted in an increase of the base per member per month (PMPM) by 1.84% and 9.65% for Child and Adult, respectively, totaling a 2.07% increase of the overall SFY 2017 base PMPM. For SFY 2018, the adjustment resulted in an increase of the base PMPM by 1.88% and 6.60% for Child and Adult, respectively, totaling a 2.13% increase of the overall SFY 2018 base PMPM.

Completion Factors

The encounter data include claims for dates of service from July 1, 2016 through June 30, 2018, and reflect payments through December 31, 2018. Mercer estimated and adjusted for the remaining liability associated with incurred but not reported claims for SFY 2018. The overall adjustment using paid claims data through December 31, 2018 was 0.10% for SFY 2018 claims. The SFY 2017 claims were deemed complete as they reflect 18 months of runout.

Fraud and Abuse Adjustment

Fraud and abuse recoveries were included in the financial reports. These recoveries were included in the development of the under-reporting adjustment.

Co-Payments and Third Party Liability

An adjustment for co-payments was not necessary for this analysis because both the Legacy Medicaid program and the DBP are not subject to co-payments. Recoveries associated with third party liability and subrogation have been removed from claims by selecting only MCO paid amounts.

TREND ADJUSTMENTS

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. Trend adjustments were based on analysis of Louisiana dental claims experience and review of dental trend

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benchmarks in other state Medicaid programs and commercial dental managed care programs. Mercer evaluated trend patterns to examine and project utilization and unit cost trends for the rate period. Total PMPM annual trend applied to Medicaid Child/CHIP is 1.63%, Medicaid Adult is 1.63%, and LaCHIP Affordable Plan is 1.13%. Total PMPM annual trend applied to Medicaid Expansion Child is 0.76% and Medicaid Expansion Adult is 1.76%.

PROGRAMMATIC CHANGES

Program change adjustments recognize the impact of benefit or eligibility changes occurring after the start of the base data period. CMS requires the rate-setting methodology used to determine actuarially sound rate ranges incorporates the results of any programmatic changes that have taken place, or are anticipated to take place, between the start of the base period and the conclusion of the contract period.

Wage Verification Disenrollment Adjustment

Effective April 1, 2019, the State implemented a new process whereby Medicaid enrollees' income data is reviewed periodically and the Medicaid eligibility of certain individuals is reevaluated. Once each quarter, the State will cross reference income data collected by other State agencies with Medicaid eligibility guidelines to identify individuals who may no longer be eligible for Medicaid. Individuals who are identified through this process are sent verification-of-wage requests. Any individuals who are unable to demonstrate their household income level is within Medicaid eligibility limits or who do not respond are disenrolled from the program at the end of the quarter. Individuals who do not respond to the wage-verification request can reapply for Medicaid at any point after they are deemed ineligible. Their application will be handled according to the State's standard process.

In order to estimate the impact of this policy change on the overall acuity of the covered populations, the State provided Mercer with a list of individuals who were identified as ineligible in the 2019 Q1 wage verification run and were subsequently disenrolled. The policy change primarily impacted the Medicaid Expansion population. Mercer estimated the relative cost of the disenrolled individuals versus the residual Medicaid Expansion population based on historical DBP encounter data. These cost relativities, in conjunction with January 1, 2019 through March 31, 2019 Medicaid Expansion enrollment data, were used to develop a baseline acuity adjustment.

Additionally, the State has observed a material number of individuals who were initially disenrolled due to the 2019 Q1 wage-verification review re-enrolling during 2019 Q2. The State provided Mercer with six weeks of re-enrollment data, which was used to adjust the enrollment projections used in this analysis. Based on this information, Mercer and the State assumed that approximately 1.7% of the individuals who were disenrolled due to the 2019 Q1 wage-verification reviews would be re-enrolled in Medicaid. The subsequent table 3 summarizes the estimated net impact of the 2019 Q1 wage-verification disenrollment on the overall acuity of Medicaid Expansion rate cells.

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TABLE 3: ESTIMATED NET IMPACT OF THE 2019 Q1 WAGE VERIFICATION DISENROLLMENT

RATE CELL	ADJUSTMENT
Medicaid Expansion Child	-0.95%
Medicaid Expansion Adult	0.59%

NON-MEDICAL EXPENSE LOAD

The proposed capitation rates shown above include provision for dental (PAHP) administration and underwriting gain. Mercer relied upon its professional experience in working with numerous commercially managed dental plans and state Medicaid programs in determining appropriate administrative expenses. The loads for administrative expenses and underwriting gain are calculated as percentages of the capitation rate net of premium tax. Finally, the capitation rates include a load for the State's premium tax, which is calculated as a percentage of the final capitation rate.

The proposed capitation rates assume a 9.25% load for administrative expenses, 2.00% underwriting gain, and 2.25% premium tax for the SFY 2020 contract period. In total, the overall non-medical expense load applied to the rates is 13.25%.

Federal Health Insurance Provider Fee (HIPF)

Section 9010 of the ACA established a 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. This fee is calculated on an annual basis. The fee will be calculated and become payable during the third quarter of 2020. As this fee is not yet defined by insurer and by marketplace, no adjustment has been made in the rate development for the DBP. An adjustment and revised certification will be considered when the fee amount and impacted entities applicable to this rate period are announced.

CERTIFICATION OF FINAL RATES

This certification assumes items in the Medicaid State Plan, as well as the DBP MCO contract, have been approved by CMS.

In preparing the capitation rate for the contract period July 1, 2019 through June 30, 2020, Mercer used and relied upon enrollment, eligibility and encounter data, fee schedule, and benefit design information supplied by the State and its fiscal agent. The State, its fiscal agent and the DBP manager are responsible for the validity and completeness of this supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. In our opinion they are appropriate for

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the intended purposes. However, if the data and information is incomplete 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 the rates were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the Medicaid and LaCHIP 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.

Capitation rates 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 DBP contractor costs will differ from these projections. Mercer has developed these rates on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.4 and accordance with applicable law and regulations. Use of these rates for any purpose beyond that stated may not be appropriate.

The DBP contractor is advised that the use of the rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of the rates by the DBP contractor for any purpose. Mercer recommends that any health plan considering contracting with the State should analyze its own projected dental expense, administrative expense, and any other premium needs for comparison to the rates 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 secure the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

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This certification letter assumes the reader is familiar with the Louisiana DBP, Medicaid eligibility rules, and actuarial rating techniques. It has been prepared exclusively 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. 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 or comments on the assumptions or methodology, please contact Kodzo Dekpe at +1 404 442 3296 or Han Lu at +1 404 442 3167.

Sincerely,

Kodzo Dekpe, ASA, MAAA
Associate

Han Lu, ASA, MAAA
Associate

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APPENDIX A

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
001	SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic	11	Hurricane Evacuees	Yes
002	Deemed Eligible	11	Hurricane Evacuees	Yes
005	SSI/LTC	11	Hurricane Evacuees	Yes
007	LACHIP Phase 1	11	Hurricane Evacuees	Yes
008	PAP - Prohibited AFDC Provisions	11	Hurricane Evacuees	Yes
009	LIFC - Unemployed Parent / CHAMP	11	Hurricane Evacuees	Yes
013	CHAMP Pregnant Woman (to 133% of FPIG)	11	Hurricane Evacuees	Yes
014	CHAMP Child	11	Hurricane Evacuees	Yes
015	LACHIP Phase 2	11	Hurricane Evacuees	Yes
020	Regular MNP (Medically Needy Program)	11	Hurricane Evacuees	Yes
021	Spend-Down MNP	11	Hurricane Evacuees	Yes
025	LTC Spend-Down MNP	11	Hurricane Evacuees	Yes

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
027	EDA Waiver	11	Hurricane Evacuees	Yes
028	Tuberculosis (TB)	20	TB	Yes
040	SLMB (Specified Low-Income Medicare Beneficiary)	01	Aged	Yes
040	SLMB (Specified Low-Income Medicare Beneficiary)	02	Blind	Yes
040	SLMB (Specified Low-Income Medicare Beneficiary)	04	Disabled	Yes
047	Illegal/Ineligible Aliens Emergency Services	01	Aged	Yes
047	Illegal/Ineligible Aliens Emergency Services	03	Families and Children	Yes
047	Illegal/Ineligible Aliens Emergency Services	04	Disabled	Yes
047	Illegal/Ineligible Aliens Emergency Services	11	Hurricane Evacuees	Yes
048	QI-1 (Qualified Individual - 1)	01	Aged	Yes
048	QI-1 (Qualified Individual - 1)	02	Blind	Yes
048	QI-1 (Qualified Individual - 1)	04	Disabled	Yes

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
049	QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)	01	Aged	Yes
049	QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)	04	Disabled	Yes
050	PICKLE	11	Hurricane Evacuees	Yes
053	CHAMP Pregnant Woman Expansion (to 185% FPIG)	11	Hurricane Evacuees	Yes
055	LACHIP Phase 3	11	Hurricane Evacuees	Yes
059	Disabled Adult Child	11	Hurricane Evacuees	Yes
062	SSI/Public ICF/DD	01	Aged	Yes
062	SSI/Public ICF/DD	02	Blind	Yes
062	SSI/Public ICF/DD	04	Disabled	Yes
062	SSI/Public ICF/DD	06	OCS Foster Care	Yes
062	SSI/Public ICF/DD	08	IV-E OCS/OYD	Yes
062	SSI/Public ICF/DD	22	OCS/OYD (XIX)	Yes

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
063	LTC Co-Insurance	01	Aged	Yes
063	LTC Co-Insurance	02	Blind	Yes
063	LTC Co-Insurance	04	Disabled	Yes
063	LTC Co-Insurance	11	Hurricane Evacuees	Yes
064	SSI/Private ICF/DD	01	Aged	Yes
064	SSI/Private ICF/DD	02	Blind	Yes
064	SSI/Private ICF/DD	04	Disabled	Yes
064	SSI/Private ICF/DD	06	OCS Foster Care	Yes
064	SSI/Private ICF/DD	08	IV-E OCS/OYD	Yes
064	SSI/Private ICF/DD	22	OCS/OYD (XIX)	Yes
065	Private ICF/DD	01	Aged	Yes
065	Private ICF/DD	02	Blind	Yes
065	Private ICF/DD	04	Disabled	Yes
065	Private ICF/DD	06	OCS Foster Care	Yes

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
065	Private ICF/DD	08	IV-E OCS/OYD	Yes
065	Private ICF/DD	22	OCS/OYD (XIX)	Yes
083	Acute Care Hospitals (LOS > 30 days)	11	Hurricane Evacuees	Yes
086	Forced Benefits	04	Disabled	Yes
088	Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	11	Hurricane Evacuees	Yes
090	LTC (Long-Term Care)	11	Hurricane Evacuees	Yes
094	QDWI	04	Disabled	Yes
095	QMB (Qualified Medicare Beneficiary)	17	QMB	Yes
099	Public ICF/DD	01	Aged	Yes
099	Public ICF/DD	02	Blind	Yes
099	Public ICF/DD	03	Families and Children	Yes
099	Public ICF/DD	04	Disabled	Yes
099	Public ICF/DD	06	OCS Foster Care	Yes
099	Public ICF/DD	08	IV-E OCS/OYD	Yes

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
099	Public ICF/DD	22	OCS/OYD (XIX)	Yes
100	PACE SSI	01	Aged	Yes
100	PACE SSI	02	Blind	Yes
100	PACE SSI	04	Disabled	Yes
101	PACE SSI-related	02	Blind	Yes
101	PACE SSI-related	01	Aged	Yes
101	PACE SSI-related	04	Disabled	Yes
102	GNOCHC Adult Parent	30	Non Traditional	Yes
103	GNOCHC Childless Adult	30	Non Traditional	Yes
104	Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL	11	Hurricane Evacuees	Yes
115	Family Planning, Previous LAMOMS eligibility	40	Family Planning	Yes
115	HPE Family Planning	16	Presumptive Eligible	Yes
116	Family Planning, New eligibility / Non LA MOM	40	Family Planning	Yes

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
116	HPE Family Planning	16	Presumptive Eligible	Yes
132	Spend-Down Denial of Payment/Late Packet	01	Aged	Yes
132	Spend-Down Denial of Payment/Late Packet	02	Blind	Yes
132	Spend-Down Denial of Payment/Late Packet	04	Disabled	Yes
136	Private ICF/DD Spend-Down Medically Needy Program	01	Aged	Yes
136	Private ICF/DD Spend-Down Medically Needy Program	02	Blind	Yes
136	Private ICF/DD Spend-Down Medically Needy Program	04	Disabled	Yes
137	Public ICF/DD Spend-Down MNP	01	Aged	Yes
137	Public ICF/DD Spend-Down Medically Needy Program	02	Blind	Yes
137	Public ICF/DD Spend-Down Medically Needy Program	04	Disabled	Yes

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
138	Private ICF/DD Spend-Down MNP/Income Over Facility Fee	02	Blind	Yes
138	Private ICF/DD Spend-Down MNP/Income Over Facility Fee	04	Disabled	Yes
139	Public ICF/DD Spend-Down MNP/Income Over Facility Fee	02	Blind	Yes
139	Public ICF/DD Spend-Down MNP/Income Over Facility Fee	04	Disabled	Yes
140	SSI Private ICF/DD Transfer of Resources	02	Blind	Yes
140	SSI Private ICF/DD Transfer of Resources	04	Disabled	Yes
141	Private ICF/DD Transfer of Resources	02	Blind	Yes
141	Private ICF/DD Transfer of Resources	04	Disabled	Yes
142	SSI Public ICF/DD Transfer of Resources	02	Blind	Yes
142	SSI Public ICF/DD Transfer of Resources	04	Disabled	Yes
143	Public ICF/DD Transfer of Resources	02	Blind	Yes
143	Public ICF/DD Transfer of Resources	04	Disabled	Yes

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
144	Public ICF/DD MNP Transfer of Resources	02	Blind	Yes
144	Public ICF/DD MNP Transfer of Resources	04	Disabled	Yes
145	Private ICF/DD MNP Transfer of Resources	02	Blind	Yes
145	Private ICF/DD MNP Transfer of Resources	04	Disabled	Yes
178	Disabled Adults authorized for special hurricane Katrina assistance	11	Hurricane Evacuees	Yes
201	LBHP - Adult 1915(i)	01	LBHP	Yes
201	LBHP - Adult 1915(i)	02	LBHP	Yes
201	LBHP - Adult 1915(i)	03	LBHP	Yes
201	LBHP - Adult 1915(i)	04	LBHP	Yes
205	LBHP - Adult 1915(i)	01	LBHP	Yes
205	LBHP - Adult 1915(i)	02	LBHP	Yes
205	LBHP - Adult 1915(i)	03	LBHP	Yes
205	LBHP - Adult 1915(i)	04	LBHP	Yes
212	Family Planning/Take Charge Transition	03	Family Planning	Yes

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
212	HPE Family Planning Elig Options	16	Presumptive Eligible	Yes

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APPENDIX B

Table 1a

			Base Data Adjustments		
	[A]	[B]	[C]	[D]	[E]
Rate Cell Description	SFY 2017 MMs	SFY 2017 PMPM	Under-reporting	IBNR	Adjusted Base PMPM
LaCHIP Affordable Plan	36,161	$ 17.47	1.84%	0.00%	$ 17.80
Medicaid Child/CHIP	9,380,094	$ 13.95	1.84%	0.00%	$ 14.20
Medicaid Adult	3,692,290	$ 1.06	9.65%	0.00%	$ 1.16
Medicaid Expansion Child			1.84%	0.00%	
Medicaid Expansion Adult			9.65%	0.00%	
Total	13,108,545	$ 10.32	2.07%	0.00%	$ 10.54

Table 1b

			Base Data Adjustments		
	[A]	[B]	[C]	[D]	[E]
Rate Cell Description	SFY 2018 MMs	SFY 2018 PMPM	Under-reporting	IBNR	Adjusted Base PMPM
LaCHIP Affordable Plan	38,541	$ 17.21	1.88%	0.10%	$ 17.55
Medicaid Child/CHIP	9,123,274	$ 14.42	1.88%	0.08%	$ 14.70
Medicaid Adult	3,524,478	$ 1.11	6.60%	0.32%	$ 1.19
Medicaid Expansion Child	456,866	$ 13.85	1.88%	0.08%	$ 14.12
Medicaid Expansion Adult	5,116,303	$ 0.77	6.60%	0.32%	$ 0.83
Total	18,259,462	$ 8.02	2.13%	0.10%	$ 8.20

Notes:
[E] = [B] x (1 + [C]) x (1 + [D])

Table 2

	Projected Benefit					
	[A]	[B]	[C]	[D]	[E]	[F]
Rate Cell Description	Combined PMPM	Annual Trend	Trend Months	Trended PMPM	Prospective Program Change	Program Change Adjusted PMPM
LaCHIP Affordable Plan	$ 17.67	1.13%	30	$ 18.18	0.00%	$ 18.18
Medicaid Child/CHIP	$ 14.45	1.63%	30	$ 15.05	0.00%	$ 15.05
Medicaid Adult	$ 1.17	1.63%	30	$ 1.22	0.00%	$ 1.22
Medicaid Expansion Child	$ 14.12	1.76%	24	$ 14.62	-0.95%	$ 14.48
Medicaid Expansion Adult	$ 0.83	0.76%	24	$ 0.84	0.59%	$ 0.84
Total[1]	$ 7.80			$ 8.11	-0.03%	$ 8.11

	Retention Load				[K]
	[G]	[H]	[I]	[J]	
Rate Cell Description	Admin %	Underwriting Gain	Premium Tax	Total	Final Loaded Rate
LaCHIP Affordable Plan	9.25%	2.00%	2.25%	13.25%	$ 20.95
Medicaid Child/CHIP	9.25%	2.00%	2.25%	13.25%	$ 17.34
Medicaid Adult	9.25%	2.00%	2.25%	13.25%	$ 1.41
Medicaid Expansion Child	9.25%	2.00%	2.25%	13.25%	$ 16.70
Medicaid Expansion Adult	9.25%	2.00%	2.25%	13.25%	$ 0.97
Total[1]	9.25%	2.00%	2.25%	13.25%	$ 9.35

Notes:
[A]= (Table 1a [A] x Table 1a [E] + Table 1b [A] x Table 1b [E]) / (Table 1a [A] + Table 1b [A])
[D] = [A] x (1 + [B])^([C] / 12)
[F] = [D] x (1 + [E])
[J] = 1 - (1 - ([G] + [H])) x (1 - [I])
[K] = [F] / (1 - [J])
1.Aggregated PMPM is based on constant enrollment mix (SFY 19-20 projected enrollment).

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APPENDIX C

Rate Cell	Jul 2018–Jun 2019 Rates	Jul 2019–Jun 2020 Rates	% Change [1]
	[A]	[B]	[C] = [B]/[A] - 1
LaCHIP Affordable Plan	$20.38	$20.95	2.8%
Medicaid Child/CHIP	$16.68	$17.34	4.0%
Medicaid Adult	$1.30	$1.41	8.5%
Medicaid Expansion Child	$15.38	$16.70	8.6%
Medicaid Expansion Adult	$1.28	$0.97	-24.2%

1.Main driver of the rate change is the new base data.

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JULY 2019–JUNE 2020 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE

Louisiana — July 1, 2019 – June 30, 2020

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

A. Rate Development Standards

i. Rate certifications must be done on a 12-month rating period.[5] CMS will consider a time period other than 12 months to address unusual circumstance. For example, CMS would approve a time period other than 12 months for the following reasons:

   a. when the state is trying to align program rating periods, which may require a rating period longer than one year (but less than two years); or

   b. when the state needs to make an amendment to the contract and the rates for an already approved rating period need to be adjusted accordingly.

ii. In accordance with 42 CFR §438.4, 438.5, 438.6, and 438.7, an acceptable rate certification submission, as supported by the assurances from the state, includes the following items and information:

   a. a letter from the certifying actuary, who meets the requirements for an actuary in 42 CFR §438.2, who certifies that the final capitation rates meet the standards in 42 CFR §438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7.

   b. the final and certified capitation rates for all rate cells in accordance with 42 CFR §438.4(b)(4), and all regions (as applicable). [6] Additionally, the contract must specify the final capitation rate(s) in accordance with 42 CFR §438.3(c)(1)(i).

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[5] Per 42 CFR §438.2, "rating period" means a period of 12 months selected by the state for which the actuarially sound capitation rates are developed and documented in the rate certification.

[6] Beginning with rate periods on or after July 1, 2018, actuaries must certify specific rates for each rate cell in accordance with 42 CFR §438.4(b)(4) and 438.7(c), and it is no longer permissible to certify rate ranges. However, 42 CFR §438.7(c)(3) allows states to increase or decrease the capitation rate per rate cell up to 1.5 percent without submitting a revised rate certification.

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

c. brief descriptions of the following information (to show that the actuary developing and/or certifying the rates has an appropriate understanding of the program for which he or she is developing rates):

i. a summary of the specific state Medicaid managed care programs covered by the rate certification, including, but not limited to:

A. the types and numbers of managed care plans included in the rate development (e.g., type should include the program type, such as managed care organizations, prepaid inpatient health plans, or prepaid ambulatory health plans).

B. a general description or list of the benefits that are required to be provided by the managed care plan or plans (e.g., types of medical services, behavioral health or mental health services, long-term care services, etc.), particularly noting any benefits that are carved out of the managed care program or that are new to the managed care program in that rating period covered.

C. the areas of the state covered by the managed care rates and approximate length of time the managed care program has been in operation.

ii. the rating period covered by the rate certification.

iii. the Medicaid population(s) covered through the managed care program(s) to which the rate certification applies.

iv. any eligibility or enrollment criteria that could have a significant influence on the specific population to be covered within the managed care program (e.g., the definition of medically frail, or if enrollment in managed care plans is voluntary or mandatory).

v. a summary of the special contract provisions related to payment that, per 42 CFR §438.6, are included within rate development (e.g. risk-sharing mechanisms, incentive arrangements, withhold arrangements, state-directed delivery system reform and provider payment initiatives,[7] pass-through payments, and payments to MCOs and PIHPs for enrollees that are a patient in an Institution of Mental Disease (IMD)).

[7] State direction of managed care plan expenditures under the contract (e.g., value-based purchasing arrangements, multi-player initiatives, quality/performance incentive programs, and all fee schedules) must meet the requirements in 42 CFR §438.6(c) and receive prior approval before implementation. In order to ensure that States can have these directed payment arrangements reviewed and approved prior to developing rates, CMS has a separate process for submitting payment arrangements under 42 CFR §438.6(c).

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

vi. if the state determines that a retroactive adjustment to the capitation rates is necessary, these retroactive adjustments must be certified by an actuary in a revised rate certification and submitted as a contract amendment in accordance with 42 CFR §438.7(c)(2). The rate certification must:

A. describe the rationale for the adjustment; and

B. the data, assumptions and methodologies used to develop the magnitude of the adjustment.

iii. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

iv. Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments from any other rate cell.

v. The effective dates of changes to the Medicaid managed care program (including eligibility, benefits, payment rate requirements, incentive programs, and program initiatives) should be consistent with the assumptions used to develop the capitation rates.

vi. Capitation rates must be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio, as calculated under 42 CFR §438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under 42 CFR §438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs. Under §438.8(j), the state may choose to impose remittance provisions related to this medical loss ratio. The terms and conditions of any remittance should clearly be outlined in the rate certification and demonstrate compliance with 438.8(c), which requires a State, that elects to mandate a minimum MLR for its MCOs, PIHPs, or PAHPs, to use a minimum MLR equal to or higher than 85 percent.

vii. As part of CMS's determination of whether or not the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles, CMS will consider whether the submission demonstrates the following:

a. all adjustments to the capitation rates, or to any portion of the capitation rates, must reflect reasonable, appropriate, and attainable costs in the actuary's judgment and must be included in the rate certification.

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

b. adjustments to the rates that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4. Therefore, the rates will not be considered actuarially sound if adjustments are made outside of the rate setting process described in the rate certification.

c. consistent with 42 CFR §438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell.

viii. Rates must be certified for all time periods in which they are effective, and a certification must be provided for rates for all time periods. Rates from a previous rating period cannot be used for a future time period without an actuarial certification of the rates for the new rating period.

ix. Procedures for rate certifications for rate and contract amendments, include:

a. CMS requires that the state submit a new rate certification when the rates change, except for changes permitted in 42 CFR §438.7(c)(3).

b. for contract amendments that do not affect the rates (except for changes permitted in 42 CFR §438.7(c)(3)), CMS does not require a new rate certification from the state. However, if the contract amendment revises the covered populations, services furnished under the contract or other changes that could reasonably change the rate development and rates, the state and its actuary must provide supporting documentation indicating the rationale as to why the rates continue to be actuarially sound in accordance with 42 CFR §438.4.

c. there are several circumstances when CMS would not require a new rate certification:

i. the state may increase or decrease capitation rate per rate cell up to 1.5 percent range, in accordance with 42 CFR §438.7(c)(3).

ii. a state applies risk scores to the capitation rates paid to the plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR §438.7(b)(5)(iii).

d. any time a rate changes for any reason other than application of an approved payment term (e.g., risk adjustment methodology), which was included in the initial managed care contract, the state must submit a contract amendment to CMS, even if the rate change does not need a new rate certification.

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

B. Appropriate Documentation	Documentation Reference
i. States and their actuaries must document all the elements described within their rate certification to provide adequate detail that CMS is able to determine whether or not the regulatory standards are met. In evaluating the rate certification, CMS will look to the reasonableness of the information contained in the rate certification for the purposes of rate development and may require additional information or documentation as necessary to review and approve the rates. States and their actuaries must ensure that the following elements are properly documented: a. data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources. b. assumptions made, including any basis or justification for the assumption. c. methods for analyzing data and developing assumptions and adjustments.	• Mercer Rate Certification
ii. The rate certification must include an index that documents the page number or the section number for the items described within this guidance. In cases where not all sections of this guidance are relevant for a particular rate certification (i.e., an amended certification that adds a new benefit for part of the year), inapplicable sections of the guidance should be included and marked as "Not Applicable" in the index.	
iii. There are services, populations, or programs for which the state receives a different federal medical assistance percentage	• Mercer Rate Certification

SECTION I. MEDICAID MANAGED CARE RATES	
1. General Information	
(FMAP) than the regular state FMAP. In those cases, the portions or amounts of the costs subject to the different FMAP should be shown as part of the rate certification to the extent possible.	- Dental Capitation Rates, Page 2
iv. CMS requests that states that operated the managed care program or programs covered by the rate certification in previous rating periods provide: a. A comparison to the final certified rates in the previous rate certification. For the first rate certification for a rating period, this should be a comparison to the prior rating period's rates or rate ranges. For rate certifications that revise or amend rates in a rating period, this should be a comparison to the latest certified rates for the rating period. If there are large, or negative changes in rates from the previous year, the actuary should describe what is leading to these differences. b. A description of any other material changes to the capitation rates or the rate development process not otherwise addressed in the other sections of this guidance.	• Mercer Rate Certification, Appendix C

SECTION I. MEDICAID MANAGED CARE RATES
2. Data
A. Rate Development Standards
i. In accordance with 42 CFR §438.5(c), states and actuaries must follow rate development standards related to base data, including:

SECTION I. MEDICAID MANAGED CARE RATES

2. Data

a. states must provide all the validated encounter data and/or fee-for-service (FFS) data (as appropriate) and audited financial reports (as defined in see §438.3(m)) that demonstrates experience for the populations to be served by the health plan to the state's actuary developing the capitation rates for at least the three most recent and complete years prior to the rating period.

b. states and their actuaries must use the most appropriate base data, from the three most recent and complete years prior to the rating period, for developing capitation rates.

c. base data must be derived from the Medicaid population, or, if data on the Medicaid population is not available, derived from a similar population and adjusted to make the utilization and price data comparable to data from the Medicaid population.

d. states that are unable to develop rates using data that is no older than from the three most recent and complete years prior to the rating period may request approval for an exception as follows:

   i. this request should be submitted by the state as soon as the actuary starts developing the rate certification and makes a determination that encounter data will not comply with 42 CFR §438.5(c)(1)-(2).

   ii. the request must describe why an exception is necessary and describe the actions the state intends to take to come into compliance with those requirements.

   iii. the request must also describe the state's proposed corrective action plan outlining how the state will come into compliance with the base data standards per 42 CFR §438.5(c) no later than two years from the rating period for which the deficiency is identified.

B. Appropriate Documentation	Documentation Reference
i. In accordance with 42 CFR §438.7(b)(1), the rate certification must include: a. a description of base data requested by the actuary for the rate setting process, including: i. a summary of the base data that was requested by the actuary. ii. a summary of the base data that was provided by the state.	• Mercer Rate Certification - Introduction, Page 2

SECTION I. MEDICAID MANAGED CARE RATES	
2. Data	
iii. an explanation of why any base data requested was not provided by the state.	
ii. The rate certification, as supported by the assurances from the state, must thoroughly describe the data used to develop the capitation rates, including: a. a description of the data, including:	
i. the types of data used, which may include, but is not limited to: fee-for-service claims data; managed care encounter data; health plan financial data; information from program integrity audits; or other Medicaid program data.	• Mercer Rate Certification - Introduction, Page 1 - Base Period Data and Enrollment, Pages 2-3
ii. the age or time periods of all data used.	• Mercer Rate Certification - Base Period Data and Enrollment, Pages 2-3
iii. the sources of all data used (e.g., State Medicaid Agency; other state agencies; health plans; or other third parties).	• Mercer Rate Certification - Introduction, Page 1 - Base Period Data and Enrollment, Pages 2-3
iv. if a significant portion of the benefits under the contract with the managed care entity are provided through arrangements with subcontractors that are also paid on a capitated basis (or subcapitated arrangements), a description of the data received from the subcapitated plans or providers; or, if data is not received from the subcapitated plans or providers, a description of how the	N/A

SECTION I. MEDICAID MANAGED CARE RATES	
2. Data	
historical costs related to subcapitated arrangements were developed or verified.	
b. information related to the availability and the quality of the data used for rate development, including:	
i. the steps taken by the actuary or by others (e.g., State Medicaid Agency; health plans; external quality review organizations; financial auditors; etc.) to validate the data, including: A. completeness of the data. B. accuracy of the data. C. consistency of the data across data sources.	• Mercer Rate Certification - Base Period Data and Enrollment, Pages 2-3 - Under-reporting, Page 4 - Completion factors, Page 4
ii. a summary of the actuary's assessment of the data.	• Mercer Rate Certification - Base Period Data and Enrollment, Pages 2-3 - Certification of Final Rates, Pages 6-7
iii. any other concerns that the actuary has over the availability or quality of the data.	N/A
c. a description of how the actuary determined what data was appropriate to use for the rating period, including:	
i. if fee-for-service claims or managed care encounter data are not used (or are not available), this description should include an explanation of why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered.	

SECTION I. MEDICAID MANAGED CARE RATES	
2. Data	
ii. if managed care encounter data was not used in the rate development, this description should include an explanation of why encounter data was not used as well as any review of the encounter data and the concerns identified which led to not including the encounter data.	N/A
d. if there is any reliance or use of a data book in the rate development, the details of the template and relevant instructions used in the data book.	N/A
iii. The rate certification, as supported by the assurances from the state, must thoroughly describe any significant adjustments, and the basis for the adjustments, that are made to the data, including but not limited to adjustments for:	
a. the credibility of the data.	• Mercer Rate Certification - Base Period Data and Enrollment, Pages 2-3 - Certification of Final Rates, Pages 6-7
b. completion factors.	• Mercer Rate Certification - Completion factors, Page 4
c. errors found in the data.	N/A
d. changes in the program between the time period from which the data is obtained and the rating period (e.g., changes in the population covered; changes in benefits or services; changes to payment models or reimbursement rates to	N/A

SECTION I. MEDICAID MANAGED CARE RATES	
2. Data	
providers; or changes to the structure of the managed care program).	
e. exclusions of certain payments or services from the data.	• Mercer Rate Certification - Base Period Data and Enrollment, Pages 2-3

SECTION I. MEDICAID MANAGED CARE RATES
3. Projected Benefit Costs and Trends
A. Rate Development Standards
i. Final capitation rates must be based only upon the services allowed in 42 CFR §438.3(c)(1)(ii) and 438.3(e).
ii. Variations in the assumptions used to develop the projected benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.
iii. In accordance with 42 CFR §438.5(d), each projected benefit cost trend assumption must be reasonable and developed in accordance with generally accepted actuarial principles and practices. Trend assumptions must be developed primarily from actual experience of the Medicaid population or from a similar population, and including consideration of other factors that may affect projected benefit cost trends through the rating period.
iv. If the projected benefit costs include costs for in-lieu-of services defined at 42 CFR §438.3(e)(2) (i.e., substitutes for State Plan services or settings), the utilization and unit costs of the in-lieu-of services must be taken into account in developing the projected benefit costs of the covered services (as opposed to utilization and unit costs of the State plan services or settings), unless a statute or regulation explicitly requires otherwise. The costs of an IMD as an in-lieu-of-service must not be used in rate development. See Section I, item 3.A.v.
v. When IMDs are used to provide in-lieu-of services, states may make a monthly capitation payment to an MCO or PIHP (in a “risk contract” as defined in 42 CFR §438.2) for an enrollee age 21 to 64 receiving inpatient treatment in an Institution for Mental Diseases (IMD) (as defined in

SECTION I. MEDICAID MANAGED CARE RATES

3. Projected Benefit Costs and Trends

42 CFR §435.1010) for a short-term stay of no more than 15 days during the period of the monthly capitation payment in accordance with 42 CFR §438.6(e). In this case, when developing the projected benefit costs for these services, the actuary must use the unit costs of providers delivering the same services included in the State Plan, as opposed to the unit costs of the IMD services. The actuary may use the utilization of the services provided to an enrollee in an IMD in developing the utilization component of projected benefit costs. The data used for developing the projected benefit costs for these services must not include:

a. costs associated with an IMD stay of more than 15 days.

b. any other costs for any services delivered during the time an enrollee is in an IMD for more than 15 days.

B. Appropriate Documentation	Documentation Reference
i. The rate certification must clearly document the final projected benefit costs by relevant level of detail (e.g., rate cell, or aligned with how the state makes payments to the plans).	• Mercer Rate Certification - Dental Capitation Rates, Page 2
ii. The rate certification and supporting documentation must describe the development of the projected benefit costs included in the capitation rates, including:	
a. a description of the data, assumptions, and methodologies used to develop the projected benefit costs and, in particular, all significant and material items in developing the projected benefit costs.	• Mercer Rate Certification, Pages 2-5
b. any material changes to the data, assumptions, and methodologies used to develop projected benefit costs since the last rate certification must be described.	• Mercer Rate Certification, Pages 2-5

SECTION I. MEDICAID MANAGED CARE RATES	
3. Projected Benefit Costs and Trends	
c. the amount of overpayments to providers and a description of how the state accounted for this in rate development. See §438.608(d).	
iii. The rate certification and supporting documentation must include a section on projected benefit cost trends (i.e. an estimate the projected change in benefit costs from the historical base data period(s) to the rating period of the rate certification) in accordance with 42 CFR §438.7(b)(2). a. this section must include:	
i. any data used or assumptions made in developing projected benefit cost trends, including a description of the sources of those data and assumptions. A. the descriptions of data and assumptions should include citations whenever possible. B. the description should state whether the trend is developed primarily with actual experience from the Medicaid population or provide rationale for the experience from a similar population that is utilized, and consideration of other factors expected to impact trend.	• Mercer Rate Certification - Trend Adjustments, Page 4-5
ii. the methodologies used to develop projected benefit trends.	• Mercer Rate Certification - Trend Adjustments, Page 4-5
iii. any comparisons to historical benefit cost trends, or other program benefit cost trends, that were analyzed as	• Mercer Rate Certification

SECTION I. MEDICAID MANAGED CARE RATES	
3. Projected Benefit Costs and Trends	
part of the development of the trend for the rating period of the rate certification.	- Trend Adjustments, Page 5
iv. documentation supporting the chosen trend rates and explanation of outlier and negative trends.	
b. this section must include the projected benefit cost trends separated into components, specifically:	
i. the projected benefit cost trends should be separated into: A. changes in price (i.e., pricing differences due to different provider reimbursement rates or payment models); and B. changes in utilization (i.e., differences in the amount, duration, or mix of benefits or services provided).	N/A
ii. if the actuary did not develop the projected benefit cost trends using price and utilization components, the actuary should describe and justify the method(s) used to develop projected benefit cost trends.	• Mercer Rate Certification - Trend Adjustments, Page 4-5
iii. the projected benefit cost trends may include other components as applicable and used by the actuary in developing rates (e.g., changes in location of service delivery; the effect of utilization or care management on projected benefit cost trends; regional differences or variations).	N/A

SECTION I. MEDICAID MANAGED CARE RATES	
3. Projected Benefit Costs and Trends	
c. variations in the projected benefit cost trends must be explained. Projected benefit cost trends may vary by: i. Medicaid populations. ii. rate cells. iii. subsets of benefits within a category of services (e.g., specialty vs. non-specialty drugs).	N/A
d. any other material adjustments to projected benefit cost trends must be described in accordance with 42 CFR §438.7(b)(4), including: i. a description of the data, assumptions, and methodologies used to determine each adjustment. ii. the cost impact of each material adjustment. iii. where in the rate setting process the material adjustment was applied.	N/A
e. any other adjustments to projected benefit costs trends must be listed. CMS also requests the following detail about non-material adjustments: i. the impact of managed care on the utilization and the unit costs of health care services. ii. changes to projected benefit costs trend in the rating period outside of regular changes in utilization or unit cost of services.	N/A
iv. If the projected benefit costs include additional services deemed by the state to be necessary to comply with the parity standards	N/A

SECTION I. MEDICAID MANAGED CARE RATES	
3. Projected Benefit Costs and Trends	
of the Mental Health Parity and Addiction Equity Act as required by 42 CFR §438.3(c)(1)(ii), the following must be described: a. the categories of service that contain these additional services necessary for parity. b. the percentage of cost that these services represent in each category of service. c. how these services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service.	
v. For in-lieu-of services defined at 42 CFR §438.3(e)(2) (i.e., substitutes for State Plan services), the following information must be provided and documented: a. the categories of covered service that contain in-lieu-of-services. b. the percentage of cost that in-lieu-of services represent in each category of service. c. how the in-lieu-of services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service. d. for inpatient psychiatric or substance use disorder services provided in an IMD setting, rate development must comply with the requirements of 42 CFR §438.6(e) and the data and	N/A

SECTION I. MEDICAID MANAGED CARE RATES	
3. Projected Benefit Costs and Trends	
assumptions utilized should be described in the rate certification.	
vi. The rate certification must describe how retrospective eligibility periods are accounted for in rate development, including but not limited to: a. the managed care plan's responsibility to pay for claims incurred during the retroactive eligibility period. b. how the claims information are included in the base data. c. how the enrollment or exposure information is included in the base data. d. how the capitation rates are adjusted to reflect the retroactive eligibility period, and the assumptions and methodologies used to develop those adjustments.	• Mercer Rate Certification - Retroactive Eligibility, Page 3
vii. The rate certification must clearly document the impact on projected costs for all material changes to covered benefits or services since the last rate certification, including, but not limited to: a. more or fewer state plan benefits covered by Medicaid managed care. b. any recoveries of overpayments made to providers by health plans in accordance with 42 CFR §438.608(d). c. requirements related to payments from health plans to any providers or class of providers. d. requirements or conditions of any applicable waivers.	N/A

SECTION I. MEDICAID MANAGED CARE RATES	
3. Projected Benefit Costs and Trends	
e. requirements or conditions of any litigation to which the state is subjected.	
viii. For each change related to covered benefits or services, the rate certification must include an estimated impact of the change on the amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment.	N/A
a. any change determined by the actuary to be non-material can be grouped with other non-material changes and described within the rate certification, provided that: i. the rate certification includes a list of all non-material adjustments used in the rate development process. ii. the actuary must give a description of why the changes were not considered material and how they were aggregated into a single adjustment. iii. the rate certification provides a description of where in the rate setting process the adjustments were applied. iv. The rate certification documents the aggregate cost impact of all non-material adjustments.	N/A

SECTION I. MEDICAID MANAGED CARE RATES
4. Special Contract Provisions Related to Payment
A. Incentive Arrangements

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

i. Rate Development Standards

a. the rate certification and supporting documentation must describe any incentives included in the contract between the state and the health plans. An incentive arrangement, as defined in 42 CFR §438.6(a), is any payment mechanism under which a health plan may receive additional funds over and above the capitation rate it was paid for meeting targets specified in the contract.

i. the rate certification must include documentation that the incentive arrangement will not exceed 105 percent of the approved capitation payments under the contract that are attributable to the enrollees or services covered by the incentive arrangements as required in 42 CFR §438.6(b)(2).

ii. Appropriate Documentation	**Documentation Reference**
a. the rate certification must include a description of the incentive arrangement. An adequate description includes at least: i. the time period of the arrangement, if different than the rating period. ii. the enrollees, services, and providers covered by the incentive program. iii. the purpose of the incentive arrangement (e.g. specified activities, targets, performance measures, or quality-based outcomes, etc.). iv. confirmation that the incentive payments will not exceed 105 percent of the capitation payments. v. a description of any effect that each incentive arrangement has on the development of the capitation rates.	N/A

B. Withhold Arrangements

i. Rate Development Standards

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

a. the rate certification and supporting documentation must describe any withhold arrangements in the contract between the state and the health plans. As defined in 42 CFR §438.6(a), a withhold arrangement is any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract.
   i. the targets for a withhold arrangement are distinct from general operational requirements under the contract.
   ii. arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement.

b. in accordance with 42 CFR §438.6(b)(3), the capitation payment(s) minus any portion of the withhold that is not reasonably achievable must be actuarially sound.

ii. Appropriate Documentation	Documentation Reference
a. the rate certification must include a description of the withhold arrangement. An adequate description includes at least the following: i. the time period of the arrangement, if different than the rating period and the purpose of the arrangement (e.g. specified activities, targets, performance measures, or quality-based outcomes, etc.). ii. a description of the total percentage of the certified capitation rates being withheld through withhold arrangements. iii. an estimate of the percentage of the withheld amount in a withhold arrangement that is not reasonably achievable and the basis for that determination, including the data, assumptions, and methodologies used to make this determination.	N/A

SECTION I. MEDICAID MANAGED CARE RATES	
4. Special Contract Provisions Related to Payment	
iv. a description of how the total withhold arrangement, achievable or not, is reasonable and takes into consideration the health plan's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the health plan's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves. v. a description of any effect that the withhold arrangements have on the development of the capitation rates. b. the rate certification must certify capitation payment(s) minus any portion of the withhold that is not reasonably achievable as actuarially sound.	
C. Risk-Sharing Mechanisms	
i. Rate Development Standards a. in accordance with 42 CFR §438.6(b), if the state utilizes risk-sharing mechanisms with its health plan(s), such as reinsurance, risk corridors, or stop-loss limits, these arrangements must be described in the contract(s) and must be developed in accordance with §438.4, the rate development standards in §438.5, and generally accepted actuarial principles and practices. b. the rate certification and supporting documentation must describe any risk mitigation that may affect the rates or the final net payments to the health plan(s) under the applicable contract.	
ii. Appropriate Documentation	**Documentation Reference**
a. the rate certification and supporting documentation must include a description of any other risk-sharing arrangements, such as a risk corridor or a large claims pool.	N/A

SECTION I. MEDICAID MANAGED CARE RATES	
4. Special Contract Provisions Related to Payment	
An adequate description of these includes at least the following: i. a rationale for the use of the risk sharing arrangement. ii. a detailed description of how the risk-sharing arrangement is implemented. iii. a description of any effect that the risk-sharing arrangements have on the development of the capitation rates. iv. documentation demonstrating that the risk-sharing mechanism has been developed in accordance with generally accepted actuarial principles and practices.	
b. if the contract includes a remittance/payment requirement for being below/above a specified medical loss ratio (MLR), the rate certification and supporting documentation must include a description of this MLR arrangement. An adequate description includes at least the following: i. the methodology used to calculate the medical loss ratio. ii. the formula for calculating a remittance/payment for having a medical loss ratio below/above the minimum requirements. iii. any other consequences for a remittance/payment for a medical loss ratio below/above the minimum requirements.	
c. if the contract has reinsurance requirements, the rate certification and supporting document must include a	

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

description of the reinsurance requirements. An adequate description includes at least the following:

i. a detailed description of any reinsurance requirements under the contract associated with the rate certification, including the reinsurance premiums and any relevant historical reinsurance experience.

ii. identification of any effect that the reinsurance requirements have on the development of the capitation rates.

iii. documentation that the reinsurance mechanism has been developed in accordance with generally accepted actuarial principles and practices.

iv. if the actuary develops the reinsurance premiums, a description of how the reinsurance premiums were developed, including the data, assumptions and methodology used.

D. Delivery System and Provider Payment Initiatives

i. Rate Development Standards

a. consistent with 42 CFR §438.6(c), states may utilize delivery system and provider payment initiatives, including requiring managed care plans to:[8]

[8] All state directed payments in Medicaid managed care contracts that are authorized under 42 CFR §438.6(c) must be based on the utilization and delivery of services to Medicaid beneficiaries covered under the contract. These payments must be directed equally, and using the same terms of performance across a class of providers. Further details on these payments are described in §438.6(c) and the CMS Informational Bulletin, dated November 2, 2017: http://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf. Payments permitted under 42 CFR §438.6(d) must be addressed as noted in section E.

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

i. implement value-based purchasing models for provider reimbursement, such as pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services.

ii. participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

iii. adopt a minimum fee schedule for network providers that provide a particular service under the contract.

iv. provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract.

v. adopt a maximum fee schedule for network providers that provide a particular service under the contract, so long as the health plan retains the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. The state's rate certification for the applicable period must address how each payment arrangement approved by CMS under 42 CFR 438.6(c) is reflected in the payments to the managed care plan from the state. Such payment arrangements can be incorporated into the base capitation rates as an adjustment to the rate or addressed through a separate payment term. When the payment arrangement is addressed through a separate payment term (e.g. instances where the state has a set pool of funding dedicated to such a payment arrangement(s)), CMS's expectations are as follows:

i. documentation related to the payment term will be included in the initial, base rate certification as outlined in Section I, Item 4.D.ii(a)(iii).

ii. when a material portion of the total capitation payment to the managed care plan for any rate cell is for directed payments addressed through separate payment terms, an estimate of the magnitude of that portion of the payment on a PMPM basis for each rate cell (CMS recognizes that this is an estimate, and that the state will provide the final figures after the payment has been made).

iii. after the rating period is complete and the state makes the payment consistent with the contract and as reflected in the initial, base rate certification, the state must submit documentation to CMS that incorporates the total amount of the payment into the rate certification's rate cells consistent with the distribution methodology described in the initial, base rate certification, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed.

iv. please note, if the total amount of the payment or distribution methodology is changed from the initial base rate certification, CMS expects the state to submit a rate amendment for the rating period, and clearly describe the magnitude of and the reason for the change.

SECTION I. MEDICAID MANAGED CARE RATES	
4. Special Contract Provisions Related to Payment	
ii. Appropriate Documentation	**Documentation Reference**
a. the rate certification and supporting documentation must include a description of any delivery system and provider payment initiatives. The documentation needed depends on which approach the state has used to incorporate the payment into its rate certification. An adequate description includes at least the following: i. a brief description of the delivery system and provider payment initiative(s) included in the rates for this rating period, including: A. the type of directed payment arrangement (minimum fee schedule, maximum fee schedule, bundled payment, etc.). B. a brief description (e.g. minimum fee schedule is set at $x as approved in the Medicaid state plan or y% of Medicare). ii. If a payment will be incorporated into the rate certification in the base capitation rates as a rate adjustment, then the following information should be included in the state's rate certification (please include this information for each separate directed payment arrangement): A. an indication of which rate cells were affected by the directed payment arrangement.	N/A

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

B. a description of how the payment arrangement is reflected in the certified capitation rates. To the extent an adjustment is applied to account for the impact of the payment arrangement, the actuary should provide a description of the data, assumptions, and methodologies used to develop the adjustment.

C. an indication that the payment is being made under an approved §438.6(c) payment arrangement in a manner that is consistent with the pre-print reviewed by CMS. To the extent the payment arrangement has not been approved by CMS before the actuary certifies the capitation rates, this should be noted in the certification and the payment arrangement that is under review should still be accounted for in rate development. In this case, the actuary should also provide an indication that the payment arrangement is accounted for in a manner consistent with the pre-print that is under CMS review.

iii. if the payment will be incorporated into the initial, base rate certification as a separate payment term, then the following information should be included in the state's rate certification (please include this information for each separate directed payment arrangement):

A. the aggregate amount of the payment applicable to the rate certification.

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

B. the provider types that will be receiving the payment.

C. the distribution methodology.

D. for a substantial payment, an estimate of the magnitude of the payment on a PMPM basis for each rate cell (CMS recognizes that this is an estimate, and that the state will provide the final figures after the payment has been made).

E. an indication that the payment is being made under an approved §438.6(c) payment arrangement in a manner that is consistent with the pre-print reviewed by CMS. To the extent the payment arrangement has not been approved by CMS before the actuary certifies the capitation rates, this should be noted in the certification and the payment arrangement that is under review should still be accounted for in rate development. In this case, the actuary should also provide an indication that the payment arrangement is accounted for in a manner consistent with the pre-print that is under CMS review.

F. A statement that after the rating period is complete the state will submit documentation to CMS, which incorporates the total amount of the payment into the rate certification's rate cells consistent with the distribution methodology described in the initial, base rate certification, and as if the payment information (e.g., providers receiving the payment,

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

amount of the payment, utilization that occurred, enrollees seen, etc.) had been fully known when the rates were initially developed.

E. Pass-Through Payments

i. Rate Development Standards

a. a pass-through payment, as defined in 42 CFR §438.6(a), is any amount required by the state to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between MCOs, PIHPs, or PAHPs and hospitals, physicians, or nursing facilities that is not for one of the following purposes: [9,10]

i. a specific service or benefit provided to a specific enrollee covered under the contract;

ii. a provider payment methodology permitted under 42 CFR §438.6(c)(1)(i) through (iii) for services and enrollees covered under the contract;

iii. a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract;

iv. Graduate Medical Education (GME) payments; or

v. Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) wrap around payments.

b. pass-through payments are allowed for transition periods as outlined in 42 CFR §438.6(d). In order to use a transition period, a state must demonstrate that it had pass-through payments for hospitals, physicians, or nursing facilities, as defined in 42 CFR §438.6(d)(1)(i), in:[11]

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[9] States may not require health plans to make pass-through payments other than those permitted to network providers that are hospitals, physicians, and nursing facilities in accordance with 42 CFR §438.6(d)(1).

[10] Pass-through payments are most easily identified as required payments that are not directly tied to utilization or outcomes based on utilization during the rating period of the contract.

[11] In accordance with 42 CFR §438.6(d)(1)(ii), CMS will not approve a retroactive adjustment or amendment, notwithstanding the adjustments to the base amount permitted in 42 CFR §438.6(d)(2), to managed cared contract(s) and rate certification(s) to add new pass-through payments or increase existing pass-through payments.

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

i. managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016, and were submitted for CMS review and approval on or before July 5, 2016; or

ii. if the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 had not been submitted to CMS on or before July 5, 2016, the managed care contract(s) and rate certification(s) for a rating period before July 5, 2016 that had been most recently submitted for CMS review and approval as of July 5, 2016.

c. pass-through payments to hospitals must comply with the requirements of 42 CFR §438.6(d).

i. in accordance with 42 CFR §438.6(d)(3), the aggregate pass-through payments to hospitals may not exceed the lesser of: (1) 80 percent of the base amount; or (2) the total dollar amount of pass-through payments to hospitals identified in the managed care contract(s) and rate certification(s) used to meet the requirement of 42 CFR §438.6(d)(1)(i).

ii. in accordance with 42 CFR §438.6(d)(5), the aggregate pass-through payments to physicians or nursing facilities may be no more than the total dollar amount of pass-through payments to physicians or nursing facilities, respectively, identified in the managed care contract(s) and rate certification(s) used to meet the requirement of 42 CFR §438.6(d)(1)(i).

d. the base amount, as defined in 42 CFR §438.6(d)(2), is determined as the sum of (i) and (ii) below:

i. for inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for the rating period that includes pass-through payments and that were provided to the eligible populations under MCO, PIHP, or PAHP contracts two years prior to the rating period, the state must determine reasonable estimates of the aggregate difference between:

A. the amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under the MCO, PIHP, or PAHP contracts for the 12-month period immediately two years prior to the rating period that will include pass-through payments; and

B. the amount the MCOs, PIHPs, or PAHPs paid (not including pass-through payments) for those inpatient and outpatient hospital services utilized by the eligible populations under MCO, PIHP, or PAHP contracts for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments.

ii. for inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for the rating period that includes pass-through payments and that were provided to the eligible populations under Medicaid FFS for

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

the 12-month period immediately 2 years prior to the rating period, the state must determine reasonable estimates of the aggregate difference between:

A. the amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments; and

B. the amount the state paid under Medicaid FFS (not including pass-through payments) for those inpatient and outpatient hospital services utilized by the eligible populations for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments.

d. in accordance with 42 CFR §438.6(d)(2)(iii), the base amount must be calculated on an annual basis and is recalculated annually.

e. the base amount should be the actual amount calculated in the Section I, Item 4.E.i.d of the guide and should not be trended forward.

f. in accordance with 42 CFR §438.6(d)(2)(iv), states may calculate reasonable estimates of the aggregate differences in paragraph (d) in accordance with the upper payment limit requirements in 42 CFR part 447.

g. capitation rates may only include pass-through payments to hospitals, physicians and nursing facilities in accordance with 42 CFR §438.6(d); states may not include pass-through payments to providers other than hospitals, physicians, and nursing facilities in the capitation rates.

ii. Appropriate Documentation	Documentation Reference
a. the rate certification and supporting documentation must include a description of all existing pass-through payments incorporated into the rates for this rating period. An adequate description includes at least the following: i. a description of the pass-through payment. ii. the amount of the pass-through payments, both in total and on a per member per month basis (if applicable). iii. the providers receiving the pass-through payments.	N/A

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

iv. the financing mechanism for the pass-through payment.

v. the amount of pass-through payments incorporated into capitation rates in the previous rating period.

vi. documentation of historical pass-through payments that are a prerequisite for authorization to use a transition period (as outlined in 42 CFR §438.6(d)(1)(i)):

A. if the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 were submitted to CMS on or before July 5, 2016, please provide:

1. the total aggregate amount of pass-through payments per provider type (i.e. hospital physician and nursing facility) incorporated into capitation rates for the rating period in effect on July 5, 2016.

2. the date(s) the managed care contract(s) and rate certification(s) were submitted to CMS for review and approval.

B. if the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 had not been submitted to CMS on or before July 5, 2016, please provide the total aggregate amount of pass-through payments by provider type incorporated into capitation rates for the rating period before July 5, 2016 that had been most recently

SECTION I. MEDICAID MANAGED CARE RATES	
4. Special Contract Provisions Related to Payment	
submitted for CMS review and approval as of July 5, 2016.	
b. in accordance with 42 CFR §438.6(d)(4), the certification must document the following information about the base amount for hospital pass-through payments: i. the data, methodologies, and assumptions used to calculate the base amount. ii. the aggregate amounts calculated for Section I, Item 4.E.i.d.i.A, Section I, Item 4.E.i.d.i.B, Section I, Item 4.E.i.d.ii.A, and Section I, 4.E.i.d.ii.B. iii. the calculation of the applicable percentage of the base amount available for pass-through payments under the schedule in Section I, Item 4.E.i.c.	N/A

SECTION I. MEDICAID MANAGED CARE RATES
5. Projected Non-Benefit Costs
A. Rate Development Standards
i. In accordance with 42 CFR §438.5(e), the development of the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO, PIHP or PAHP administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital. In addition, the non-benefit component must include other operational costs associated with the provision of services under the contract, including those to comply with the parity standards of the Mental Health Parity and Addiction Equity Act, as required by 42 CFR §438.3(c)(1)(ii).

SECTION I. MEDICAID MANAGED CARE RATES

5. Projected Non-Benefit Costs

ii. Non-benefit costs may be developed as per member per month (PMPM) costs or as a percentage of projected benefit costs or capitation rates, and different approaches can be taken for different categories of costs. For non-benefit costs that may be difficult to allocate to specific enrollees or groups of enrollees, or for taxes and fees that are assessed as a percentage of premiums, it may be reasonable to calculate those non-benefit costs as a percentage of benefit costs or capitation rates.

iii. Variations in the assumptions used to develop the projected non-benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

iv. Section 9010 of the Patient Protection and Affordable Care Act imposes a Health Insurance Providers Fee on each covered entity engaged in the business of providing health insurance for United States health risk. CMS policy regarding how this fee may be considered in Medicaid managed care rate development is outlined in CMS's "Medicaid and CHIP FAQs: Health Insurance Providers Fee for Medicaid Managed Care Plans," dated October 2014.[12] States have the flexibility to account for the Health Insurance Providers Fee on a prospective or retrospective basis into rate development for either the data year or fee year. Any payment for the fee must be incorporated in the health plan capitation rates.

   a. due to the health insurance provider fee moratorium established by the Consolidated Appropriations Act of 2016 and continuing resolution legislation, Pub. Law. 115-120 (H.R. 195), Division D – Suspension of Certain Health-Related Taxes, § 4003,CMS does not expect any health insurance provider fees to be paid for calendar year 2017 and 2019 by managed care plans that are subject to that fee. Therefore, no amounts should be included in Medicaid managed care capitation rates for fees that would have been paid by plans to the IRS for 2017 or 2019 (which would have been assessed off of 2016 and 2018 net premiums, respectively).[13] This fee remains in effect for calendar year 2018 and beyond 2019.

[12] https://www.medicaid.gov/federal-policy-guidance/downloads/faq-10-06-2014.pdf

[13] More information on this issue can be found at: https://www.irs.gov/Businesses/Corporations/Affordable-CareAct-Provision-9010

SECTION I. MEDICAID MANAGED CARE RATES

5. Projected Non-Benefit Costs

B. Appropriate Documentation	Documentation Reference
i. The rate certification and supporting documentation must describe the development of the projected non-benefit costs included in the capitation rates in enough detail so CMS or an actuary applying generally accepted actuarial principles and practices can identify each type of non-benefit expense that is included in the rate and evaluate the reasonableness of the cost assumptions underlying each expense in accordance with 42 CFR §438.7(b)(3). To meet this standard, the documentation must include: a. a description of the data, assumptions, and methodologies used to develop the projected non-benefit costs, and in particular, all significant and material items in developing the projected non-benefit costs. b. any material changes to the data, assumptions, and methodologies used to develop projected non-benefit costs since the last rate certification. c. any other material adjustments must be described in accordance with 42 CFR §438.7(b)(4), including: i. a description of the data, assumptions, and methodologies used to determine each adjustment. ii. where in the rating setting process each adjustment was applied. iii. the cost impact of each material adjustment.	• Mercer Rate Certification - Administrative Load, Page 6

SECTION I. MEDICAID MANAGED CARE RATES	
5. Projected Non-Benefit Costs	
ii. States and actuaries should estimate the projected non-benefit costs for each of the following categories of costs: a. administrative costs. b. taxes, licensing and regulatory fees, and other assessments and fees. c. contribution to reserves, risk margin, and cost of capital. d. other material non-benefit costs.	• Mercer Rate Certification - Administrative Load, Page 6
iii. Regarding the Health Insurance Providers Fee, the rate certification and supporting documentation must: a. specifically address how this fee is incorporated into capitation rates if the managed care plan is required to pay the fee for 2020. b. if the fee is incorporated into the rates in the initial rate certification, an explanation of whether the amount included in the rates is based on the data year or fee year during the rating period of the rate certification. c. a description of how the amount of the fee was determined, and whether or not any adjustments would be made to the rates once the actual amount of the fee is known. d. if the fee is not incorporated into the rates in the rate certification because the rates will be adjusted to account for the fee subsequently, an explicit statement that the fee is not included, and a description of when and how the rates will ultimately be adjusted to account for the fee.	• Mercer Rate Certification - Federal Health Insurance Provider Fee, Pages 6

SECTION I. MEDICAID MANAGED CARE RATES

5. Projected Non-Benefit Costs

e. if the capitation rates include benefits as described in 26 CFR §57.2(h)(2)(ix) (e.g., long-term care, nursing home care, home health care, or community-based care), CMS recommends that the per member per month cost associated with those benefits be explicitly reported as a separate amount in the rate certification in order to more accurately account for the appropriate revenue on which the plans will be assessed.

f. for managed care plans that were required to pay the fee in 2014, 2015, 2016, and/or 2018, a description as to whether or not the fee has been included in the capitation rates for those years (either prospectively in the rates or through amendments to the initially certified rates).

SECTION I. MEDICAID MANAGED CARE RATES

6. Risk Adjustment and Acuity Adjustments

A. Rate Development Standards

i. Risk adjustment is a methodology to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of MCOs, PIHPs, or PAHPs contracted with the state.

ii. As required by 42 CFR §438.5(g), if risk adjustment is applied prospectively or retrospectively, states and their actuaries must select a risk adjustment methodology that uses generally accepted models and must apply it in a budget neutral manner, consistent with generally

SECTION I. MEDICAID MANAGED CARE RATES

6. Risk Adjustment and Acuity Adjustments

accepted actuarial principles and practices, across all MCOs, PIHPs or PAHPs in the program to calculate adjustments to the payments as necessary.

iii. An adjustment applied to the total payments across all managed care plans to account for significant uncertainty about the health status or risk of a population is considered an acuity adjustment, which is a permissible adjustment under 42 CFR §438.5(f) (81 FR 27595).

a. acuity adjustments may be used prospectively or retrospectively.

b. while retrospective acuity adjustments may be permissible, they are intended solely as a mechanism to account for differences between assumed and actual health status when there is significant uncertainty about the health status or risk of a population, such as: (1) new populations coming into the Medicaid program; or (2) a Medicaid population that is moving from FFS to managed care when enrollment is voluntary and there may be concerns about adverse selection. In the latter case, there may be significant uncertainty about the health status of which individuals would remain in FFS versus move to managed care; although this uncertainty is expected to decrease as the program matures.

c. CMS may also consider acuity adjustments as a risk mitigation strategy when there is unusual and significant uncertainty about the health status of the population (e.g., covering a new population in Medicaid).

B. Appropriate Documentation	Documentation Reference
i. In accordance with 42 CFR §438.7(b)(5)(i), the rate certification must describe all prospective risk adjustment methodologies, including: a. the data, and any adjustments to that data, to be used to calculate the adjustment. b. the model, and any adjustments to that model, to be used to calculate the adjustment. c. the method for calculating the relative risk factors and the reasonableness and appropriateness of the method in measuring the risk factors of the respective populations.	N/A

SECTION I. MEDICAID MANAGED CARE RATES	
6. Risk Adjustment and Acuity Adjustments	
d. the magnitude of the adjustment on the capitation rate per MCO, PIHP, or PAHP. e. an assessment of the predictive value of the methodology compared to prior rating periods. f. any concerns the actuary has with the risk adjustment process.	
ii. In accordance with 42 CFR §438.7(b)(5)(ii), the rate certification must describe all retrospective risk adjustment methodologies, including: a. the party calculating the risk adjustment. b. the data, and any adjustments to that data, to be used to calculate the adjustment. c. the model, and any adjustments to that model, to be used to calculate the adjustment. d. the timing and frequency of the application of the risk adjustment. e. any concerns the actuary has with the risk adjustment process.	N/A
iii. The rate certification and supporting documentation must also specifically include: a. any changes that are made to risk adjustment models since the last rating period. b. documentation that the risk adjustment model is budget neutral in accordance with 42 CFR §438.5(g).	N/A

SECTION I. MEDICAID MANAGED CARE RATES

6. Risk Adjustment and Acuity Adjustments

iv. If an acuity adjustment is being used, the rate certification must include a description of the acuity adjustment and its basis that is adequate to evaluate its reasonableness and whether it is consistent with generally accepted actuarial principles and practices. Such a description includes at least:

a. the reason that there is significant uncertainty about the health status of the population and the need for an acuity adjustment.

b. the acuity adjustment model(s) being used to calculate acuity adjustment scores.

c. the specific data, including the source(s) of the data, being used by the acuity adjustment model(s).

d. the relationship and potential interactions between the acuity adjustment.

e. how frequently the acuity adjustment scores are calculated.

f. a description of how the acuity adjustment scores are being used to adjust the capitation rates.

g. documentation that the acuity adjustment mechanism has been developed in accordance with generally accepted actuarial principles and practices.

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS

1. Managed Long-Term Services and Supports

A. For managed long-term services and supports (MLTSS) programs, or for programs that include MLTSS as part of the covered benefits, the guidance above in Section I regarding the required standards for rate development and CMS's expectations for appropriate documentation required in the rate certification is also applicable for rates for provision of MLTSS.

B. Rate Development Standards

i. States may take different approaches for rate setting for MLTSS. The two most common approaches are to structure the rate cells:
   a. by health care status and the level of need of the beneficiaries ("blended"); or
   b. by the long-term care setting that the beneficiary uses ("non-blended").

C. Appropriate Documentation	Documentation Reference
i. The rate certification and supporting documentation for MLTSS programs, or for programs that include MLTSS as part of the covered benefits must also specifically address the following considerations: a. the structure of the capitation rates and rate cells or rating categories (e.g. blended, non-blended, etc.). b. the structure of the rates and the rate cells, and the data, assumptions, and methodology used to develop the rates in light of the overall rate setting approach. c. any other payment structures, incentives, or disincentives used to pay the MCOs, PIHPs or PAHPs (for example, states may provide additional payments to plans that transition beneficiaries from institutional long-term care settings into other settings, or may pay adjusted rates during time periods of setting transitions).	N/A

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS	
1. Managed Long-Term Services and Supports	
d. the expected effect that managing LTSS has on the utilization and unit costs of services. e. any effect that the management of this care is expected to have within each care setting and any effect in managing the level of care that the beneficiary receives (e.g., in-home care, community long-term care, nursing facility care).	
ii. The projected non-benefit costs, such as administrative costs and care coordination costs, may differ for populations receiving MLTSS from other managed care programs, and the rate certification should describe how the projected non-benefit costs were developed for populations receiving these services.	N/A
iii. The rate certification should provide information on historical experience, analysis, and other sources (e.g., studies or research) used to develop the assumptions used for rate setting.	N/A

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
1. Data	
A. In addition to the expectations for all Medicaid managed care rate certifications, as supported by assurances from the State, described in Section I, the rate certification must describe any data used to develop new adult group rates.	N/A

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
1. Data	
B. For states that have covered the new adult group in Medicaid managed care plans in previous rating periods (i.e. starting in 2014, 2015, 2016, and/or January through June 2017), CMS expects the rate certification, as supported by assurances from the State, to describe: i. Any new data that is available for use in this rate setting. ii. How the state and the actuary followed through on any plans to monitor costs and experience for newly eligible adults. iii. How actual experience and costs in previous rating periods have differed from assumptions and expectations in previous rate certifications. iv. How differences between projected and actual experience in previous rating periods have been used to adjust these rates.	N/A

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
2. Projected Benefit Costs	
A. In addition to the guidance for all Medicaid managed care rate certifications described in Section I, states should include in the rate certification submission and supporting documentation a description of the following issues related to the projected benefit costs for the new adult group:	

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
2. Projected Benefit Costs	
i. For states that covered the new adult group in previous rating periods:	
a. any data and experience specific to newly eligible adults covered in previous rating periods that was used to develop projected benefits costs for capitation rates.	N/A
b. any changes in data sources, assumptions, or methodologies used to develop projected benefits costs for capitation rates since the last rate certification.	N/A
c. how assumptions changed from rate certification(s) for previous rating periods on the following issues: i. acuity or health status adjustments (in most cases comparing the new adult group enrollees to other Medicaid adult enrollees). ii. adjustments for pent-up demand. iii. adjustments for adverse selection. iv. adjustments for the demographics of newly eligible adults. v. differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for newly eligible adult rates and other Medicaid population rates. 1. variations in the assumptions used to develop the projected benefit costs for covered populations must	N/A

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
2. Projected Benefit Costs	
be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations. vi. other material adjustments to newly eligible adults projected benefit costs.	
B. For any state that is covering the new adult group, regardless if they have been covered in previous rating periods, the following key assumptions related to the new adult group must be included in the rate certification and supporting documentation: i. Acuity or health status adjustments (in most cases comparing new adult group enrollees to other Medicaid adult enrollees). ii. Adjustments for pent-up demand. iii. Adjustments for adverse selection. iv. Adjustments for the demographics of the new adult group. v. Differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for the new adult group rates and other Medicaid population rates. vi. Other material adjustments to the new adult group projected benefit costs.	N/A
C. The rate certification and supporting documentation must describe any changes to the benefit plan offered to the new adult group.	N/A

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
2. Projected Benefit Costs	
D. The rate certification and supporting documentation must describe any other material changes or adjustments to projected benefit costs.	N/A

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
3. Projected Non-Benefit Costs	
A. In addition to the guidance all Medicaid managed care rate certifications described in Section I, states must include in the rate certification submission and supporting documentation a description of the following issues related to the projected non-benefit costs for the new adult group: i. For states that covered the new adult group in Medicaid managed care plans in previous rating periods, any changes in data sources, assumptions, or methodologies used to develop projected non-benefit costs since the last rate certification. ii. How assumptions changed from the rate certification(s) for previous rating periods on the following issues: a. administrative costs. b. care coordination and care management. c. provision for operating or profit margin. d. taxes, fees, and assessments. e. other material non-benefit costs.	N/A

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
3. Projected Non-Benefit Costs	
B. The rate certification and supporting documentation must include information on key assumptions related to the new adult group and any differences between the assumptions for this population and the assumptions used to develop projected non-benefit costs for other Medicaid populations for the following issues: i. Administrative costs. ii. Care coordination and care management. iii. Provision for operating or profit margin. iv. Taxes, fees, and assessments. v. Other material non-benefit costs.	N/A

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
4. Final Certified Rates	
A. In addition to the expectations for all Medicaid managed care rate certifications described in Section I, CMS requests under 42 CFR §438.7(d)[14] that states that covered the new adult group in Medicaid managed care plans in previous rating periods provide:	N/A

[14] The regulation provides: (d) *Provision of additional information.* The State must, upon CMS' request, provide additional information, whether part of the rate certification or additional supplemental materials, if CMS determines that information is pertinent to the approval of the certification under this part. The State must identify whether or not the information provided in addition to the rate certification is proffered by the State, the actuary, or another party.

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
4. Final Certified Rates	
i. A comparison to the final certified rates or rate ranges in the previous rate certification. ii. A description of any other material changes to the capitation rates or the rate development process not otherwise addressed in the other sections of this guidance.	

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
5. Risk Mitigation Strategies	
A. CMS requests under 42 CFR §438.7(d) that states describe the risk mitigation strategy specific to the new adult group rates.	N/A
B. For states that covered the new adult group in Medicaid managed care plans in previous rating periods, CMS requests the following information: i. Any changes in the risk mitigation strategy from those used during previous rating periods. ii. The rationale for making the change in the risk mitigation strategy or removing the risk mitigation used during previous rating periods. For states that utilize a risk mitigation strategy specific to the new adult group for the initial rating period that included this population, CMS believes this risk mitigation strategy should continue to be utilized until the following three criteria are met:	N/A

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
5. Risk Mitigation Strategies	
a. the state uses data only from the new adult group's experience to develop capitation rates; b. the state has settled or reconciled previous risk mitigation terms in their contract (e.g., MLR, risk corridor) to assess the appropriateness of their previous rate development; and c. the state can demonstrate that capitation rates are stable, or that rates have been adjusted consistent with differences in early experience. iii. Any relevant experience, results, or preliminary information available related to the risk mitigation strategy used during previous rating periods.	

DAVID MCKEON, DDS

Louisiana Executive Director

Louisiana Key Personnel Position: DBPM CEO

Degrees and Licensure –Doctor of Dental Surgery, LSU School of Dentistry (1991), Bachelor of Arts in Biology, University of New Orleans (1986); Louisiana Dental License (1991)

Medicaid Project Management Experience – Dr. McKeon has served as Executive Director of Dental Health Resources for the LSU School of Dentistry for 10 years, serving as the Dental Director for the Louisiana Dental Medicaid Program. He joined MCNA in 2014 to continue his leadership in the Medicaid Program as Executive Director and Chief Executive Officer.

Qualifying Experience – Since 2009, Dr. McKeon has provided overall direction for the Louisiana Dental Medicaid Program through strategy development, formulation of policies and the Medicaid Dental Services Manual and other training materials, and the development of special reporting in support of efficient operations and to ensure that deliverables are met.

Location – 40+ hours a week at the LSU School of Dentistry and MCNA's Louisiana Office

Dr. David McKeon has been a licensed dentist in Louisiana since 1991 after graduating from the Louisiana State University (LSU) School of Dentistry. He served Medicaid enrolled children in Louisiana for over a decade before becoming the State's Dental Director for the Medicaid and CHIP programs in 2009. Dr. McKeon joined MCNA in 2014 as our Louisiana Executive Director to provide seamless leadership for our Louisiana plan, and will fulfill the role of MCNA's Louisiana Chief Executive Officer.

Dr. McKeon provides overall direction for our Louisiana plan. He works closely with our Executive Management Team to develop strategies, formulate all Louisiana-specific policies as necessary, and oversee general plan operations to ensure we meet all deliverables in a timely manner. He also oversees provider network recruitment and management activities within the State in collaboration with our Network Development team. Dr. McKeon leads MCNA's Louisiana Dental Advisory Committee, serving as our primary link with the professional dental community to ensure MCNA is responsive to network provider feedback. He also serves as an invaluable liaison to the LSU School of Dentistry, maintaining open lines of communication at all times which facilitates our successful relationship with our state partners.

Experience

Louisiana Executive Director (2014 - Present)
MCNA Insurance Company, New Orleans, Louisiana

Responsible for overall development and management of MCNA Insurance Company's utilization review process for the State of Louisiana.

- Implements the strategic goals and objectives of the organization.
- Takes the lead for provider and stakeholder communications.
- Oversees the Louisiana-based plan staff.
- Serves as a liaison for utilization management and quality improvement activities.
- Assists with Louisiana provider network recruitment and management.
- Oversees the activities of the MCNA's Louisiana Dental Advisory Committee.

Director, Dental Health Resources Dental Authorization Unit (2009 - 2014)
Assistant Clinical Professor, Dental Health Resources (2002 - 2009)
Louisiana State University School of Dentistry, New Orleans, Louisiana

Served as Dental Consultant for the Louisiana Department of Health (LDH).

- Served in an advisory capacity to LDH in regard to dental related issues.
- Assisted LDH in the preparation, review, and revision of the Medicaid Dental Services Manual, training manuals, or other dental related projects upon request of LDH.
- Assisted LDH upon request with the preparation of special reports necessary to ensure the proper function of the Louisiana Dental Medicaid Program.
- Assisted in the recovery of funds paid inappropriately to providers when discovered during the usual scope of work.
- Participated in LDH's statewide dental provider training workshops.
- Attended meetings and other dental related functions as required by LDH.
- Helped LDH apply individual medical necessity reviews, when appropriate, for EPSDT and EDSPW program services that were not otherwise covered by Medicaid.
- Served as a liaison with LDH.

Clinical Reviewer and Staff Dentist (1997 - 2002)
DENTAmax Plus Dental Plan, Metairie, Louisiana

- Served as clinical reviewer for the appropriateness of care provided to DENTAmax plan members.
- Provided comprehensive dental care and preventive services to patients, including oral health education about the appropriate brushing and flossing techniques, tobacco cessation, and proper nutrition.

Private Practice (1991 - 1997)
Michael Adams Family Dentistry, Gretna, Louisiana
David McKeon, D.D.S., Marrero, Louisiana
Altman Family Dentistry, Slidell, Louisiana
Manhattan Family Dentistry, Harvey, Louisiana

- Provided comprehensive general dental care and preventive services for children and families.
- Conducted oral health exams, which included caries risk assessments.
- Treated patients for dental injuries.

- Presented treatment options to and completed informed consent with patient guardians and caregivers.
- Provided oral health education to patients and parents.
- Practiced and enforced patient safety standards and infection control.
- Ensured patient records were documented appropriately.

Education

- **Louisiana State University School of Dentistry,** New Orleans, Louisiana, Doctor of Dental Surgery (1991)
- **University of New Orleans,** New Orleans, Louisiana, Bachelor of Arts in Biology (1986)

Professional Licenses and Associations

- Licensed Dentist – Louisiana (1991)
- Member, American Dental Association
- Member, Louisiana Dental Association
- Member, New Orleans Dental Association

MICHAEL GIORLANDO, DDS, M.ED

Louisiana Dental Director

Louisiana Key Personnel Position: Louisiana Dental Director

Degrees and Licensure – Master of Education, University of New Orleans (1987); Doctor of Dental Surgery, LSU School of Dentistry (1984); Bachelor of Science, Spring Hill College (1980); Louisiana Dental License (1984)

Medicaid Project Management Experience – Dr. Giorlando has served as Administrative Faculty for the Dental Health Resources Department at LSU School of Dentistry and as MCNA's Dental Director for the Louisiana Dental Medicaid Program for over 5 years.

Qualifying Experience – Dr. Giorlando is a Louisiana-licensed Doctor of Dental Surgery with no restrictions or other licensure limitations. Since 2014, Dr. Giorlando has led the formulation of MCNA's quality management policies, our Utilization Review Criteria and Guidelines, to ensure that they comply with all applicable state and federal statutes and regulations. He makes final utilization review decisions in conjunction with MCNA's Clinical Reviewers and addresses all quality of care issues for our Louisiana members.

Location - 40+ hours a week at the LSU School of Dentistry and MCNA's Louisiana Office

Dr. Michael Giorlando has been a Louisiana-licensed Doctor of Dental Surgery since 1984. His career has spanned service as an Assitant Clinical Professor for the LSU School of Dentistry, operation of a private practice serving children and adults through the LSU Faculty Practice, and years of executive leadership as the Director of Athletics at Loyola University. In 2014, he returned to the LSU School of Dentistry as an administrative faculty member in the Dental Health Resources Department. That same year he joined MCNA as our Louisiana Dental Director to provide expert guidance for the authorization of medically necessary dental services.

Dr. Giorlando provides expert oversight of the clinical review process for our members. He oversees development and adoption of our Utilization Review Criteria and Guidelines to ensure that they comply with all applicable state and federal statutes and regulations. In addition to making final utilization review decisions in conjunction with our Clinical Review team and addressing quality of care issues for our Louisiana members, Dr. Giorlando supports our relationship with the professional dental community. He regularly participates in all Louisiana Dental Advisory Committee activities and facilitates peer-to-peer consultations between network providers and MCNA Clinical Reviewers.

Experience

Louisiana Dental Director (2014 – Present)
MCNA Insurance Company, New Orleans, Louisiana

Provides oversight and management of MCNA Insurance Company's Clinical Reviewers for the State of Louisiana.

- Represents MCNA regarding clinical issues, utilization review, and quality of care issues.
- Complies with applicable federal and state statutes and regulations.
- Guides the dental service authorization process for Medicaid members.
- Responsible for maintaining current Louisiana utilization review guidelines and criteria.
- Assists with Louisiana provider network recruitment and management.
- Facilitates peer-to-peer discussions between participating providers and MCNA's Clinical Reviewers.
- Participates in MCNA's Louisiana Dental Advisory Committee meetings.

Administrative Faculty (2014 – Present)
Louisiana State University School of Dentistry, Dental Health Resources Department, New Orleans, Louisiana

Director of Athletics and Wellness / Head Men's Basketball Coach (2004 – 2014)
Loyola University New Orleans, New Orleans, Louisiana

- Served in dual role as Director of Athletics and Head Men's Basketball Coach with oversight over the nine sports making up the university's athletics program.
- Managed annual budget of $1.6 million, including the development of effective fundraising opportunities to drive capital improvements and fund athletic scholarships.
- Oversaw all medical and insurance contracts and claims, and negotiated all contracts pertaining to sports medicine and physician staff.
- Oversaw continuous student athlete recruitment and ensured academic eligibility and compliance for all sports.
- Oversaw sports information activities including press and media relations, news releases, statistics, news conferences, and game management.

NCAA Certified Recruiter (1997 – 2004)
Assistant Men's Basketball Coach (1997 – 2004)
Louisiana State University, Baton Rouge, Louisiana
University of New Orleans, New Orleans, Louisiana

- Oversaw day-to-day coaching and player development.
- Organized, presented, and implemented $2 million men's basketball budget at Louisiana State University.
- Developed and implemented the first Academic Support Service Program for the men's basketball program at University of New Orleans.

Assistant Clinical Professor (1984 – 1992)
Louisiana State University School of Dentistry, Oral Medicine and Radiology Department, New Orleans, Louisiana

- Provided clinical instruction to first, second, and third year dental students.
- Courses taught included oral medicine and radiology, treatment planning, and hands-on clinical labs.

Private Practice (1984 – 1992)
Louisiana State University School of Dentistry Faculty Practice, New Orleans, Louisiana

Provided comprehensive general dental care and preventive services to children and families through the LSU School of Dentistry's on-campus dental clinic.

- Conducted oral health exams, which included caries risk assessments.
- Performed general dental procedures including operative, veneers, dental implants, root canals, extractions, and fixed and removable prosthetics with traditional techniques.
- Presented treatment options to and completed informed consent with patient guardians and caregivers.
- Provided oral health education to patients and parents.
- Practiced and enforced patient safety standards and infection control.
- Ensured patient records were documented appropriately.

Education

- **University of New Orleans,** New Orleans, Louisiana, Master of Education (1987)
- **Louisiana State University School of Dentistry,** New Orleans, Louisiana, Doctor of Dental Science (1984)
- **Spring Hill College,** Mobile, Alabama, Bachelor of Science (1980)

Professional Licenses and Associations

- Licensed Dentist – Louisiana (1984)
- Member, Louisiana Dental Association
- Member, American Dental Association
- Member, Academy of General Dentistry
- Member, New Orleans Dental Association

SHANNON BOGGS-TURNER

Executive Vice President

Shannon Boggs-Turner has over 20 years of experience in the analysis and implementation of state and federal regulations, and oversight of plan operations in cooperation with state regulatory agencies, including her service as Medicaid Commissioner for the Commonwealth of Kentucky. In 2012, Shannon joined MCNA as Vice President of Operations to implement our Texas Medicaid and CHIP plan. She continues this operational focus in the role of Executive Vice President.

Shannon is a proven executive with superb analytical skills and a wealth of experience in the management of both government sector and commercial health plans. Shannon provides daily oversight of all non-clinical operational functions in-house and from our affiliated third-party administrator, Managed Care of North America, Inc., including claims processing, quality improvement, utilization management, provider relations, network development, case management, call center operations, and credentialing. Under her guidance, MCNA continuously works to optimize business processes through interdepartmental integration, ensuring the expectations of our state partners are met. Shannon regularly represents MCNA with LDH, other state regulatory agencies, and professional dental organizations such as the Louisiana Dental Association. Her skills in the analysis and implementation of state and federal regulations help to ensure that MCNA's operational focus in Louisiana is compliant with all requirements.

Experience

Executive Vice President (2018 - Present)
Vice President of Operations (2012 - 2018)
MCNA Insurance Company, San Antonio, Texas

Provides overall direction and guidance to the non-clinical operational activities of the company, with the objective of optimizing business processes, integrating all operational departments, and ensuring client service level agreements are met.

- Member of Executive Management Team.
- Provides daily oversight of non-clinical operational functions including claims processing, quality improvement, utilization management, provider relations, network development, case management, call center operations, and credentialing.
- Represents MCNA with state regulatory agencies and organizations such as the Texas Dental Association, Texas Academy of Pediatric Dentistry, and Texas Academy of General Dentists.

- Decreased Medicaid dental program costs by approximately 25% for the State of Texas through the implementation of managed care using evidence-based utilization management criteria.
- Created the first comprehensive dental pay-for-quality model known as the Stellar Treatment and Recognition Reward (STARR) Program.

Managing Partner (2010 - 2012)
Consulting Strategies Team, LLC, Frankfort, Kentucky

As a founding partner of the firm, delivered consulting services to clients in both public and private sector health care programs.

- Provided full service health care consulting services including grant writing, RFP response preparation, client strategy development, revenue cycle management, contract negotiations, and project management.
- Facilitated client understanding of the impact of the Patient Protection and Affordable Care Act.
- Responsible for several highly successful RFP responses in 2011.

Executive Vice President (2006 - 2011)
University Health Care, Inc., d/b/a Passport Health Plan, Louisville, Kentucky

Provided oversight for plan operations and reported directly to the CEO and Board of Directors.

- Oversaw all aspects of daily operations for the Medicaid and Medicare Advantage lines of business for the plan with annual revenues of $1 billion.
- Implemented quality initiatives that led to the consistent national ranking of Passport as one of America's Top 25 Medicaid Managed Care plans by the National Committee for Quality Assurance (NCQA).
- Increased the health plan reserves by nearly $50 million.

Associate Vice President for Health Affairs (2007 - 2010)
University of Louisville, Louisville, Kentucky

Provided leadership for the operation of health care services for the university and advisory assistance to other associated university health care facilities.

- Helped lead the university's initiative to lower employee health care costs through the implementation of disease state management programs.
- Served as health care policy advisor to the University President.

Medicaid Commissioner (2004 - 2006)
Commonwealth of Kentucky, Frankfort, Kentucky

Oversaw a nearly $5 billion program with direct management of over 150 employees.

- Received approval for the nation's first Deficit Reduction Act based Medicaid Transformation.

- Introduced the State's first pharmacy benefits administrator, procured a new MMIS system, and contracted a Medicaid Administrative Agent to provide disease and case management services.

Compliance Officer and Director of Governmental Relations and Appeals (2001 - 2004)
Bluegrass Family Health, Lexington, Kentucky

Oversaw compliance program and corporate relationships with governmental regulatory agencies.

- Responsible for all plan compliance with applicable state and federal laws and regulations.
- Implemented all aspects of HIPAA including privacy, security, and transaction code sets.

Education

- **Villanova University**, Radnor Township, Pennsylvania, Lean Six Sigma Black Belt Master Certificate (2017)
- **University of Kentucky College of Law**, Lexington, Kentucky, Juris Doctor (2000)
- **Georgetown College**, Georgetown, Kentucky, Bachelor of Arts in Political Science/Psychology (1997)

MCNA INSURANCE COMPANY
UNANIMOUS WRITTEN CONSENT OF DIRECTORS

June 14, 2019

The undersigned, being all of the members of the board of directors (the "***Board of Directors***") of MCNA Insurance Company, a Texas accident and health insurance company (the "***Corporation***"), hereby consent to the following actions:

WHEREAS, the Louisiana Department of Health (the "***LDH***") desires to contract with the Corporation to administer the dental benefits of its Medicaid and Children's Health Insurance (CHIP) program enrollees for a period of one year commencing on July 1, 2019 (the "***Contract***");

WHEREAS, the Chief Executive Officer of the Corporation, has reviewed the Contract and recommends that the Corporation enter into the Contract with LDH; and

WHEREAS, the terms and conditions of the Contract have been reviewed by the undersigned members of the Board of Directors;

IT IS THEREFORE, RESOLVED, that Glen Feingold, Executive Vice President and Chief Operating Officer, or in his absence, Carlos Lacasa, Senior Vice President and General Counsel, are hereby authorized to execute the Contract and any additional documents ancillary thereto, and to take such other actions as necessary to complete the contracting process with LDH.

BE IT FURTHER RESOLVED, that any and all actions taken, done or performed in connection with the Contract and the authority granted by the foregoing resolution, as well as any and all actions, of any nature whatsoever, heretofore taken by any director, officer, employee, agent, attorney or other representative of the Corporation incidental to, contemplated by, arising out of or in connection with, or otherwise relating to, in any manner whatsoever, the subject of the foregoing resolution, are hereby approved, ratified and confirmed in all respects as the act and deed of the Corporation.

[Signature Page Follows]

IN WITNESS WHEREOF, the undersigned have executed the unanimous written consent in multiple counterparts, to be effective as of the date first written above, each of which together shall be considered one original, and whether by original or facsimile signature shall be effective in all respects as though an original.

Jeffrey Feingold, D.D.S., M.S.D.

Glen Feingold

Barbara Feingold

Gary Clarke, Esq.

Carlos Lacasa

Albert Hawkins

Jack Greenman

Sam Hammer

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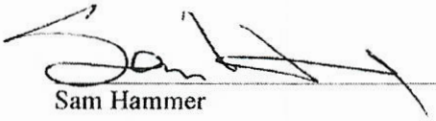
Jack Greenman



Sam Hammer

Provider Name: MCNA Insurance Company

LOUISIANA MEDICAID OWNERSHIP DISCLOSURE INFORMATION – ENTITY/BUSINESS

Must be completed in its entirety. Refer to Instructions found at www.lamedicaid.com

SECTION I – DISCLOSING ENTITY/BUSINESS PROVIDER INFORMATION

Louisiana Medicaid Provider Number (Leave blank if applying for new number)	2	3	6	5	5	8	4

Taxpayer ID Number	5	2	2	4	5	9	9	6	9

National Provider Identifier (NPI)	1	2	2	5	1	9	3	7	5	8

This enrollment packet is for a
☐ New Enrollment ■ Update to Current Enrollment
☐ Re-Validation ☐ Re-Enrollment

☐ Change of Ownership (CHOW) _____ (Date of CHOW) _____ (Current Medicaid Provider Number)

Provider Type: PAHP - Dental

Primary Telephone Number of Disclosing Entity/Business: (800) 494-6262

Doing Business As (DBA) Name	Legal Name of Disclosing Entity/Business		
MCNA Dental	MCNA Insurance Company		
Primary Disclosing Entity/Business Street Address: 200 West Cypress Creek Road, Suite 500	City: Fort Lauderdale	State: FL	Zip: 33309
Primary Disclosing Entity/Business Mailing Address/PO Box: Same	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Disclosing Entity/Business Telephone number to request medical records: (800) 494-6262 Ext. 164	Disclosing Entity/Business Primary Fax Number: (954) 252-3988		
Email Address of Entity/Business contact person: clacasa@mcna.net	Entity/Business Website (if applicable): http:/www.mcna.net		

A. ☐ **Yes** ■ **No** **Is there a Corporate Office location separate from the primary location of the disclosing Entity/Business?**

If yes, complete the section below.

DBA Name of Corporate Office			
Corporate Office Street Address	City	State	Zip
Corporate Office Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Corporate Office Phone Number ( ) -	Corporate Office Fax Number ( ) -		
Corporate Office Email address			

Provider Name: MCNA Insurance Company

Make a photocopy of this page if more space is needed to list additional locations

B. ☒ **Yes** ☐ **No** **Does the disclosing Entity/Business have any business locations in addition to the primary location listed above (i.e. satellite, branch or regional locations) related to Louisiana healthcare services?** Lists are not acceptable.

1 If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location:

DBA Name of Additional Location	Medicaid Provider #, if applicable		
MCNA Insurance Company			
Additional Location Street Address	City	State	Zip
4400 NW Loop 410, Suite 250	San Antonio	Tx	78229
Additional Location Mailing Address/PO Box	City	State	Zip
200 West Cypress Creek Road, Suite 500	Fort Lauderdale	FL	33309
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number	Additional Location Fax Number		
(800) 494-6262	(210) 853-4946		
Additional Location Email address	sturner@mcna.net		

DBA Name of Additional Location	Medicaid Provider #		
Additional Location Street Address	City	State	Zip
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Medicaid Provider #		
Additional Location Street Address	City	State	Zip
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

Provider Name: MCNA Insurance Company

Make a photocopy of this page if more space is needed to respond to item E below

C. Identify how this disclosing Entity/Business is registered with the Internal Revenue Service

Select only one (1) – multiple selections may result in a rejection for clarification

Privately Owned or Non-profit Providers Only

☐ **Sole Proprietorship**

☐ **Partnership/Limited Liability Partnership:** How many members are identified with this partnership? _____

☒ **Corporation:** Revenue greater than or equal to $5M annually X Revenue less than $5M annually _____

In the (current) Articles of Incorporation: How many stakeholders/individual owners are identified? 1

How many Board of Director members are identified? 8

How many officers are identified? 3

☐ **Limited Liability Corporation (LLC)**
In the (current) Articles of Organization: How many members are identified? _____

How many managing employees are identified? _____

☐ **Non-profit:** How many members are appointed to the governing board? _____ (Must attach IRS verification showing the non-profit status)

Comments: _____

Louisiana Government Providers Only

☐ **CITY and/or PARISH**

☐ **DCFS**

☐ **LDH**
☐ OBH ☐ OPH
☐ OAAS ☐ OCDD
☐ Villa ☐ Other _____

☐ **LEA (Local Education Agency)**

☐ **LSU**
Hospital - _____

☐ **Other State-owned entity:** _____

D. ☐ **Yes** ☒ **No** **Is this disclosing Entity/Business publicly traded? See instructions.**

E. ☐ **Yes** ☒ **No** **Has this disclosing Entity/Business used or previously been known by any name other than the Legal name or the Doing Business As (DBA) name documented in this application?**

If yes, list all names and Tax IDs below. Attach additional pages if needed.

Name	Tax ID
Name	Tax ID
Name	Tax ID
Name	Tax ID
Name	Tax ID

Provider Name: MCNA Insurance Company

SECTION II – DISCLOSING ENTITY/BUSINESS CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

Check the appropriate yes or no box regarding the questions below.
Every item needs to have either a yes or no check.
Do not leave any blanks.

A. Has this Entity/Business (since its existence) – AND –

Any Entity/Business affiliated with the same Tax ID number – AND –

Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs) as follows:

☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: MCNA Insurance Company

Make a photocopy of this page if more space is needed to respond to item A below

SECTION III – ENROLLMENT IN HEALTHCARE PROGRAMS

A. ☒ **Yes** ☐ **No** **Is the disclosing Entity/Business and the disclosing Entity/Business Tax ID listed in Section I currently enrolled in a Federal/State Funded healthcare program?**
If yes, provide the details in the fields below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
Medicaid	MCNA Dental	52-2459969	TX	
"	"		IA	
"	"		ID	
"	"		NE	
"	"		AR	
"	"		UT	

SECTION IV - PREPARER INFORMATION – INDIVIDUAL COMPLETING THE DISCLOSURE OF OWNERSHIP

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Carlos	A		Lacasa		

Social Security Number	Date of Birth	Job Title
265-89-4095	12/06/1963	SVP and General Counsel

The person completing this form is (please check one):

☒ Staff ☐ Owner ☐ Third Party/Independent Agent ☐ Other (explain) _____

Entity/Business Address	Entity/Business City	Business State	Business Zip
200 West Cypress Creek Road, Suite 500	Fort Lauderdale	FL	33309

Entity/Business Telephone Number	Entity/Business Email Address
(800) 494-6262	clacasa@mcna.net
Additional Entity/Business Telephone Number(s)	Additional Entity/Business Email Address(es)

Provider Name: MCNA Insurance Company

NEW FORMAT! PLEASE REFER TO THE INSTRUCTIONS FOR DETAILED EXPLANTIONS!

Make a photocopy of this page if more space is needed to list owners in items A and B

SECTION V(a) – INFORMATION ON ALL OWNERS

A. Individuals & Entities/Businesses with Direct Ownership

List all individual owners or entities/businesses that have any direct stake/shareholding/ownership/or controlling interest of 5% or greater in the disclosing Entity/Business.

*Fill out Section V(b) for each **Individual**. Fill out both item B and Section V(c) for each **Entity/Business** listed below.*

Individuals or Entities/Businesses with ownership	% of ownership
1. MCNA Health Care Holdings, LLC	100
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

B. Individuals and Entities/Businesses with an Indirect Ownership Stake of 5% or more in the disclosing Entity/Business

List all Entity/Business/Organizations identified in item A that have direct ownership in the disclosing Entity/Business. Identify the owners of that Entity/Business and their % of ownership below.* The disclosing Entity/Business cannot be listed as an owner.

*Fill out Section V(b) for each **Individual** and Section V(c) for each **Entity/Business** listed below.*

Entity/Business/Organization with a direct ownership interest listed in item A	Owners of the Entity/Business identified on the left.	% of ownership in Entity/Business identified on the left	% of ownership in the disclosing Entity/Business
1. MCNA Health Care Holdings, LLC	a. Dr. Jeffrey P. Feingold	7.6	
	b. Barbara Feingold, Trustee	53.9	
	c. Glen Feingold	30	
	d. Samantha Feingold	5	
2.	a.		
	b.		
	c.		
	d.		
3.	a.		
	b.		
	c.		
	d.		
4.	a.		
	b.		
	c.		
	d.		
5.	a.		
	b.		
	c.		
	d.		

*The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if individual A owns 10% percent of the stock in a corporation which owns 80% of the stock in the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if individual B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported.

Provider Name: MCNA Insurance Company

Make a photocopy and complete Section V(b) for each individual owner named in Section V(a)

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

A. INDIVIDUAL OWNER INFORMATION

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Jeffrey	P		Feingold		

Title/Job Position within the disclosing Entity/Business	% ownership	Social Security Number (required)	Date of Birth
CEO / President	7.6%	027-34-8500	01/03/46

Healthcare NPI (if applicable)

Street Address	City	State	Zip Code
7410 Sedona Way	Delray Beach	FL	33446
Mailing Address/PO Box	**City**	**State**	**Zip Code**

Telephone Number	Email address
561-665-0991	JrFeingold@mcna.net

B. ☐ Yes ☒ No **Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?**

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No **Is this owner a U.S. citizen? If no, provide Alien Verification** _____

D. ☒ Yes ☐ No **Does this owner reside outside the State of Louisiana?**

☐ Yes ☒ No If yes, has this owner been issued any Medicaid or Medicare provider numbers by the domicile state?
If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:
Domicile State:	Medicaid Provider Number:	Medicare Provider Number:

E. ☒ Yes ☐ No **Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?**

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Barbara	S.		Feingold		
☒ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship: Spouse		Job Title: Vice President
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Glen	S.		Feingold		
☒ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship: Son		Job Title: COO
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Samantha	M	Feingold	Cain		
☒ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship: Daughter		Job Title: County General Counsel
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:

Provider Name: MCNA Insurance Company

Make a photocopy of this page if more space is needed to respond to items F and G below

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: Dr. Jeffrey P. Feingold

F. ☐ Yes ☒ No **Does the individual owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?**
If yes, complete the section below for each subcontractor.

Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		

G. ☒ Yes ☐ No **Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business that participates in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
Medicaid	managed care of North America, Inc	65-0508964	FL	000130700

Provider Name: MCNA Insurance Company

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: Dr. Jeffrey P. Ferguson

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
H. Has the individual owner named above (ever):	
☐ Yes ☒ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☒ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☒ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☒ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☒ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☒ No	Currently have any open or pending healthcare court cases?
☐ Yes ☒ No	Been denied malpractice insurance?
☐ Yes ☒ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. SUBMIT A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: MCNA Insurance Company

Make a photocopy and complete Section V(b) for each individual owner named in Section V(a)

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

A. INDIVIDUAL OWNER INFORMATION

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Glen	S		Feingold		

Title/Job Position within the disclosing Entity/Business	% ownership	Social Security Number (required)	Date of Birth
COO	30%	267 - 91 - 1497	11/25/79

Healthcare NPI (if applicable)

Street Address	City	State	Zip Code
1750 Royal Palm Way	Boca Raton	FL	33432
Mailing Address/PO Box	**City**	**State**	**Zip Code**
SAME			

Telephone Number	Email address
305-218-1507	SFeingold@mcna.net

B. ☐ Yes ☒ No **Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?**

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No **Is this owner a U.S. citizen? If no, provide Alien Verification** _____

D. ☒ Yes ☐ No **Does this owner reside outside the State of Louisiana?**

☐ Yes ☒ No If yes, has this owner been issued any Medicaid or Medicare provider numbers by the domicile state?
If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:
Domicile State:	Medicaid Provider Number:	Medicare Provider Number:

E. ☒ Yes ☐ No **Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?**

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Jeffrey	P.		Feingold		
☑ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship: Son		Job Title: CEO
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Barbara	S.		Feingold		
☑ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship: Son		Job Title: VP
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Samantha	M.	Feingold	Cruz		
☑ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title: Dep. Gen. Counsel
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:

Provider Name: MCNA Insurance Company

Make a photocopy of this page if more space is needed to respond to items F and G below

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: Glen S. Feingold

F. ☐ Yes ☒ No **Does the individual owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?**
If yes, complete the section below for each subcontractor.

Subcontractor Business Name		Subcontractor Business Owner Name		
Subcontractor Address		City	State	Zip Code
Telephone Number - -	Email address			
Subcontractor Business Name	Subcontractor Business Owner Name			
Subcontractor Address	City	State	Zip Code	
Telephone Number - -	Email address			
Subcontractor Business Name	Subcontractor Business Owner Name			
Subcontractor Address		City	State	Zip Code
Telephone Number - -	Email address			
Subcontractor Business Name	Subcontractor Business Owner Name			
Subcontractor Address		City	State	Zip Code
Telephone Number - -	Email address			

G. ☒ Yes ☐ No **Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business that participates in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
Medicaid	Managed Care of North America, Inc.	65-0303864	FL	000130700

Provider Name: MCNA Insurance Company

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: Gordon S. Ferguson IV

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
H. Has the individual owner named above (ever):	
☐ Yes ☒ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☒ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☒ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☒ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☒ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☒ No	Currently have any open or pending healthcare court cases?
☐ Yes ☒ No	Been denied malpractice insurance?
☐ Yes ☒ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. SUBMIT A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: MCNA Insurance Company

Make a photocopy and complete Section V(b) for each individual owner named in Section V(a)

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

A. INDIVIDUAL OWNER INFORMATION

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Samantha	m	Feingold	Reiss		

Title/Job Position within the disclosing Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Deputy General Counsel	5	589-36-7908	08/04/85

Healthcare NPI (if applicable)

Street Address	City	State	Zip Code
16808 Charles River Drive	Delray Beach	FL	33446
Mailing Address/PO Box	**City**	**State**	**Zip Code**
same			

Telephone Number	Email address
561-665-0991	SFeingold@mcna.net

B. ☑ **Yes** ☐ **No** **Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?**

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Samantha	m.	Feingold	Reiss		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ **Yes** ☐ **No** **Is this owner a U.S. citizen? If no, provide Alien Verification** _____

D. ☒ **Yes** ☐ **No** **Does this owner reside outside the State of Louisiana?**

☐ Yes ☒ No If yes, has this owner been issued any Medicaid or Medicare provider numbers by the domicile state?

If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:
Domicile State:	Medicaid Provider Number:	Medicare Provider Number:

E. ☑ **Yes** ☐ **No** **Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?**

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Tiffiny	P.		Feingold		
☑ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship: Daughter		Job Title: CEO
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Barbara	S.		Feingold		
☑ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship: Daughter		Job Title: VP
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Erica	S.		Feingold		
☑ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship: Sister		Job Title: COO
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:

Provider Name: MCNA Insurance Company

Make a photocopy of this page if more space is needed to respond to items F and G below

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: Samantha M. Fenson

F. ☐ Yes ☒ No **Does the individual owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?**
If yes, complete the section below for each subcontractor.

Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		

G. ☑ Yes ☐ No **Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business that participates in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
Medicaid	Managed Care of North America, Inc.	65-0303864	FL	000130700

Provider Name: MCNA Insurance Company

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: Samtha M. Feingold

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
H. Has the individual owner named above (ever):	
☐ Yes ☒ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☒ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☒ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☒ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☒ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☒ No	Currently have any open or pending healthcare court cases?
☐ Yes ☒ No	Been denied malpractice insurance?
☐ Yes ☒ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. SUBMIT A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: MCNA Insurance Company

Make a photocopy and complete Section V(b) for each individual owner named in Section V(a)

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

A. INDIVIDUAL OWNER INFORMATION

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Barbara	S.		Fensold		

Title/Job Position within the disclosing Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Trustee, Jeffrey P. Fensold 2014 Irr. Trust	49.9	139 -38 -3299	07/20/51

Healthcare NPI (if applicable)

Street Address	City	State	Zip Code
7140 Sedona Way	Delray Beach	FL	33446
Mailing Address/PO Box	**City**	**State**	**Zip Code**

Telephone Number	Email address
561 - 498 - 1105	jrfensold@mcna.net

B. ☐ Yes ☒ No **Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?**

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No **Is this owner a U.S. citizen? If no, provide Alien Verification** _____

D. ☒ Yes ☐ No **Does this owner reside outside the State of Louisiana?**

☐ Yes ☒ No If yes, has this owner been issued any Medicaid or Medicare provider numbers by the domicile state?
If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:
Domicile State:	Medicaid Provider Number:	Medicare Provider Number:

E. ☒ Yes ☐ No **Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?**

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Jeffrey	P.		Fensold		
☒ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship: Spouse		Job Title: CEO
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Glen	S.		Fensold		
☒ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship: Son		Job Title: COO
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Samantha	M.	Fensold	Ellis		
☒ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship: Daughter		Job Title: Dep. Gen. Counsel
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:

Provider Name: MCNA Insurance Company

Make a photocopy of this page if more space is needed to respond to items F and G below

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: Barbara S. Kinzel, Trustee

F. ☐ Yes ☑ No **Does the individual owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?**
If yes, complete the section below for each subcontractor.

Subcontractor Business Name		Subcontractor Business Owner Name		
Subcontractor Address		City	State	Zip Code
Telephone Number - -	Email address			
Subcontractor Business Name	Subcontractor Business Owner Name			
Subcontractor Address	City	State	Zip Code	
Telephone Number - -	Email address			
Subcontractor Business Name	Subcontractor Business Owner Name			
Subcontractor Address		City	State	Zip Code
Telephone Number - -	Email address			
Subcontractor Business Name	Subcontractor Business Owner Name			
Subcontractor Address		City	State	Zip Code
Telephone Number - -	Email address			

G. ☑ Yes ☐ No **Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business that participates in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
Medicaid	managed care of North America, Inc.	65-0203804	FL	00013070O

Provider Name: MCNA Insurance Company

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: Barbara S. Kenyon, Trustee

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
H. Has the individual owner named above (ever):	
☐ Yes ☒ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☒ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☒ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☒ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☒ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☒ No	Currently have any open or pending healthcare court cases?
☐ Yes ☒ No	Been denied malpractice insurance?
☐ Yes ☒ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. SUBMIT A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: MCNA Insurance Company

Make photocopies of the next 2 pages to complete Section V(c) for each Entity/Business owner named in Section V(a) AND/OR make a photocopy of this page if more space is needed to respond to item E

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

A. ENTITY/BUSINESS OWNER INFORMATION

DBA Name	Legal Name of Entity/Business	Tax ID Number (required)
	MCNA Health Care Holdings, LLC	45-254-2951

Entity/Business Street Address – Primary Location	City	State	Zip
200 Set Cypress Creek Road, Suite 500	Fort Lauderdale	FL	33309

Entity/Business Mailing Address/PO Box	City	State	Zip
Same			

Additional Post Office Boxes Not Identified Above	City	State	Zip

Telephone Number	Fax Number
(800) 494-6262 - Ext. 163	(954) 628-3337 -

Email address of Entity/Business contact person	Entity/Business Website (if applicable)
clacasa@mcna.net	www.mcna.net

B. ☐ **Yes** ■ **No** **Are there any business locations in addition to the location listed above?**

If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location:

DBA Name of Additional Location	Tax ID Number		

Additional Location Mailing Address/PO Box	City	State	Zip

Additional Location Street Address	City	State	Zip

Additional Post Office Boxes Not Identified Above	City	State	Zip

Additional Location Phone Number	Additional Location Fax Number
( ) -	( ) -

Additional Location Email address

DBA Name of Additional Location	Tax ID Number		

Additional Location Mailing Address/PO Box	City	State	Zip

Additional Location Street Address	City	State	Zip

Additional Post Office Boxes Not Identified Above	City	State	Zip

Additional Location Phone Number	Additional Location Fax Number
( ) -	( ) -

Additional Location Email address

C. ☐ **Yes** ■ **No** **Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?**

If yes, list all names and Tax IDs below. Attach additional pages if needed.

Name		Tax ID	
Name		Tax ID	
Name		Tax ID	

Provider Name: MCNA Insurance Company

Make a photocopy of this page if more space is needed to respond to item E below

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: MCNA Health Care Holdings, LLC

D. ■ Yes ☐ No Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?

If yes, complete the section below for each subcontractor.

Subcontractor Business Name MCNA Insurance Company	Subcontractor Business Owner Name MCNA Health Care Holdings, LLC		
Subcontractor Address 200 West Cypress Creek Road, Suite 500	City Fort Lauderdale	State FL	Zip Code 33309
Telephone Number - - 800-494-6262	Email address clacasa@mcna.net		
Subcontractor Business Name Managed Care of North America, Inc.	Subcontractor Business Owner Name MCNA Health Care Holdings, LLC		
Subcontractor Address 200 West Cypress Creek Road, Suite 500	City Fort Lauderdale	State FL	Zip Code 33309
Telephone Number - - 800-494-6262	Email address clacasa@mcna.net		
Subcontractor Business Name MCNA Systems Corp d/b/a Adaxa	Subcontractor Business Owner Name MCNA Health Care Holdings, LLC		
Subcontractor Address 00 West Cypress Creek Road, Suite 500	City Fort Lauderdale	State FL	Zip Code 33309
Telephone Number (800) 494-6262	Email address clacasa@mcna.net		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		

E. ☐ Yes ■ No Is this Entity/Business and Tax ID currently listed in Section I currently enrolled in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: MCNA Insurance Company

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: MCNA Health Care Holdings, LLC

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks. F. Has this Entity/Business (since its existence) – AND – Any Entity/Business affiliated with the same Tax ID number – AND – Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs), as follows:	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: MCNA Insurance Company

Make a photocopy of this page if more space is needed to list individuals.

SECTION VI(a) – INFORMATION ON ALL MANAGING EMPLOYEES/AGENTS

List all AGENTS and INDIVIDUALS who are part of management.

Agent(s)/Member(s)/Officer(s)	Is this agent also an owner?	% ownership
1. Dr. Jeffrey P. Feingold, President	■ Yes ☐ No	Indirect 7.6%
2. Edward Strongin, Treasurer	☐ Yes ■ No	
3. Carlos Lacasa, Secretary	☐ Yes ■ No	
4.	☐ Yes ■ No	
5.	☐ Yes ☐ No	
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Managing employee(s)	Is this managing employee also an owner?	% ownership
1. Mayre Herring	☐ Yes ■ No	
2. Shannon Boggs- Turner	☐ Yes ■ No	
3. Dr. Carlos Garcia	☐ Yes ■ No	
4. Glen Feingold	■ Yes ☐ No	Indirect 30%
5.	☐ Yes ☐ No	
6.	☐ Yes ☐ No	
7.	☐ Yes ☐ No	
8.	☐ Yes ☐ No	
9.	☐ Yes ☐ No	
10.	☐ Yes ☐ No	
11.	☐ Yes ☐ No	
12.	☐ Yes ☐ No	
13.	☐ Yes ☐ No	
14.	☐ Yes ☐ No	
15.	☐ Yes ☐ No	
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Provider Name: MCNA Insurance Company

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ **AGENT– or –** ☒ **MANAGING EMPLOYEE**

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Carlos	A.		Lacasa		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Senior Vice President and General Counsel	0	265-89-4055	12 / 06 / 63

Mailing Address/PO Box	City	State	Zip Code
5690 SW 84 Terr	Miami	FL	33143
Physical Address	**City**	**State**	**Zip Code**
same			

Telephone Number	Email address
305-962-3911	clacasa@mcna.net

B. ☐ **Yes** ☒ **No** **Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?**

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ **Yes** ☐ **No** **Is this agent or managing employee a U.S. citizen?** If no, provide Alien Verification # _____

D. ☐ **Yes** ☒ **No** **Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?**

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Mcca Insurance Company

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Carlos A. Lacasa

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ☒ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☒ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☒ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☒ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☒ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☒ No	Currently have any open or pending healthcare court cases?
☐ Yes ☒ No	Been denied malpractice insurance?
☐ Yes ☒ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ **Yes** ☒ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: MCNA Insurance Company

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ **AGENT– or –** ☒ **MANAGING EMPLOYEE**

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Clifford	P		Ferguson		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
CEO / Pres. Joint	7.6 %	027-34-8500	01/03/46

Mailing Address/PO Box	City	State	Zip Code
7410 Sedona Way	Delray Beach	FL	33446

Physical Address	City	State	Zip Code

Telephone Number	Email address
- -	

B. ☐ **Yes** ☒ **No** **Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?**

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ **Yes** ☐ **No** **Is this agent or managing employee a U.S. citizen?** If no, provide Alien Verification # _____

D. ☒ **Yes** ☐ **No** **Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?**

If yes, list all Individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Glen	S		Ferguson		
Relationship: Son			Job Title: COO		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Samantha	M	Ferguson	Cass		
Relationship: Daughter			Job Title: Asst. General Counsel		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Barbara	S		Ferguson		
Relationship: Spouse			Job Title: VP		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: MCNA Insurance Company

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Dr. Jeffrey P. Kenyon

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ☒ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☒ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☒ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☒ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☒ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☒ No	Currently have any open or pending healthcare court cases?
☐ Yes ☒ No	Been denied malpractice insurance?
☐ Yes ☒ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☒ **Yes** ☐ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
Medicaid	managed care of north America, Inc.	65-0303964	FL	000130700

Provider Name: MCNA Insurance Company

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ **AGENT– or –** ☒ **MANAGING EMPLOYEE**

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Mayre		Hearing	Thompson		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Chief Compliance Officer	0	267 - 99 - 2038	03 / 21 / 76

Mailing Address/PO Box	City	State	Zip Code
11140 Heron Bay Blvd #223	Coral Springs	FL	33076
Physical Address	**City**	**State**	**Zip Code**
Same			

Telephone Number	Email address
850 - 284 - 6103	mhearing@mcna.net

B. ☒ **Yes** ☐ **No** **Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?**

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Mayre		Hearing			
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ **Yes** ☐ **No** **Is this agent or managing employee a U.S. citizen?** If no, provide Alien Verification # _____

D. ☐ **Yes** ☒ **No** **Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?**

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: MCNA Insurance Company

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Mayde Herring Thompson

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ☒ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☒ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☒ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☒ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☒ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☒ No	Currently have any open or pending healthcare court cases?
☐ Yes ☒ No	Been denied malpractice insurance?
☐ Yes ☒ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ **Yes** ☒ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: MCNA Insurance Company

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ☒ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Shannon	R		TURNER		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Vice President of Operations	0	460-15-0685	08/11/76

Mailing Address/PO Box	City	State	Zip Code
404 Elm Valley Drive	Burnet	TX	78163
Physical Address	**City**	**State**	**Zip Code**
Same			

Telephone Number	Email address
859-948-7667	STURNER@MCNA.NET

B. ☒ Yes ☐ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Shannon	R	Boggs			
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: MCNA Insurance Company

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Shannon Turner

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ☒ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☒ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☒ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☒ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☒ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☒ No	Currently have any open or pending healthcare court cases?
☐ Yes ☒ No	Been denied malpractice insurance?
☐ Yes ☒ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ☒ No **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: MCNA Insurance Company

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ **AGENT– or –** ☒ **MANAGING EMPLOYEE**

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Carlos	O		Garcia		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Dental Director	0	584-34-6865	07/05/50

Mailing Address/PO Box	City	State	Zip Code
PO Box 691265	San Antonio	TX	78269
Physical Address	**City**	**State**	**Zip Code**
7203 Cresta Bulivar	San Antonio	TX	78256

Telephone Number	Email address
956-792-2974	drgarcia@mcna.net

B. ☐ **Yes** ☒ **No** **Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?**

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ **Yes** ☐ **No** **Is this agent or managing employee a U.S. citizen?** If no, provide Alien Verification # _____

D. ☐ **Yes** ☒ **No** **Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?**

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: MCNA Insurance Company

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Dr. Carlos O. Garcia

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ☒ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☒ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☒ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☒ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☒ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☒ No	Currently have any open or pending healthcare court cases?
☐ Yes ☒ No	Been denied malpractice insurance?
☐ Yes ☒ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ **Yes** ☒ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: MCNA Insurance Company

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ **AGENT– or –** ☒ **MANAGING EMPLOYEE**

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Glen	S		Feinzoln		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
COO	30%	267 - 91 - 1497	11 / 25 / 79

Mailing Address/PO Box	City	State	Zip Code
1750 Royal Palm Way	Boca Raton	FL	33432
Physical Address	**City**	**State**	**Zip Code**
Same			

Telephone Number	Email address
305 - 215 - 1507	GFeinzoln@mcna.net

B. ☐ **Yes** ☒ **No** **Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?**

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ **Yes** ☐ **No** **Is this agent or managing employee a U.S. citizen?** If no, provide Alien Verification # _____

D. ☒ **Yes** ☐ **No** **Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?**

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Jeffrey	P.		Feinzoln		
Relationship: Son			Job Title: CEO / President		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Barbara	S		Feinzoln		
Relationship: Son			Job Title: VP		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Samantha	Jill	Feinzoln	Chiss		
Relationship: Brother			Job Title: Dep. Gen. Counsel		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: MCNA Insurance Company

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Erica S. Fairgold

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ☒ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☒ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☒ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☒ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☒ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☒ No	Currently have any open or pending healthcare court cases?
☐ Yes ☒ No	Been denied malpractice insurance?
☐ Yes ☒ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☒ **Yes** ☐ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
Medicaid	Managed Care of North America, Inc.	65-0303804	FL	000130700

Provider Name: MCNA Insurance Company

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ **AGENT– or –** ☒ **MANAGING EMPLOYEE**

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Edward			Strong		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
CFO	0	262-64-3172	02/28/50

Mailing Address/PO Box	City	State	Zip Code
2722 NW 84 Terr	Coopa City	FL	33024
Physical Address	**City**	**State**	**Zip Code**
Same			

Telephone Number	Email address
305-219-0169	Estrong12@mcna.net

B. ☐ **Yes** ☒ **No** **Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?**

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ **Yes** ☐ **No** **Is this agent or managing employee a U.S. citizen?** If no, provide Alien Verification # _____

D. ☐ **Yes** ☒ **No** **Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?**

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Mcra Ambulance Company

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Edward Strong, II

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ☒ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☒ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☒ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☒ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☒ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☒ No	Currently have any open or pending healthcare court cases?
☐ Yes ☒ No	Been denied malpractice insurance?
☐ Yes ☒ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ **Yes** ☒ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

SECTION VII – AUTHORIZED REPRESENTATIVES

THE FOLLOWING INDIVIDUALS ARE AUTHORIZED TO SIGN INTO LEGAL, BINDING DOCUMENTS ON BEHALF OF THIS PROVIDER, SUCH AS DIRECT DEPOSIT FORMS AND/OR CHANGES TO THE DISCLOSURE OF OWNERSHIP FORMS, etc.

Note: Every person listed below must be disclosed in the Disclosure of Ownership forms.

List each person authorized to sign and identify their position in your practice.	
1. Dr. Jeffrey P. Feingold	■ Owner ■ Managing employee ☐ Other _____
2. Glen Feingold	■ Owner ■ Managing employee ☐ Other _____
3. Edward Strongin	☐ Owner ■ Managing employee ☐ Other _____
4. Carlos Lacasa	☐ Owner ■ Managing employee ☐ Other _____
5.	☐ Owner ☐ Managing employee ☐ Other _____
6.	☐ Owner ☐ Managing employee ☐ Other _____
7.	☐ Owner ☐ Managing employee ☐ Other _____
8.	☐ Owner ☐ Managing employee ☐ Other _____
9.	☐ Owner ☐ Managing employee ☐ Other _____
10.	☐ Owner ☐ Managing employee ☐ Other _____

Please sign in blue ink (not black)

Carlos Lacasa
Printed Name of Authorized Representative

Signature of Authorized Representative
(sign in blue ink)

SVP and General Counsel
Title/Position

March 29, 2019
Date of Signature

SECTION VIII – PROVIDER SIGNATURE

With my signature below, I attest:

1. That the provider has disclosed all necessary information;
2. That I am the authorized representative of this entity/business and, as such, have the authority to enter into a provider agreement with the Louisiana Medicaid Program;
3. That the provider has reviewed the information on this entity/business Disclosure form and attest that it is true, accurate and complete;
4. That the provider understands that knowingly and willfully failing to fully and accurately disclose the information requested may result in the denial of any request to participate in Louisiana's Medicaid Program, or where the entity/business already participates, a termination of the provider agreement or contract with the State Agency or the Secretary, as appropriate;
5. That the provider understands that a denial or termination of the provider agreement or contract with the State Agency or the Secretary will prohibit me from any participation in Louisiana's Medicaid Program;
6. That the provider understands that whoever knowingly and willfully makes or causes to be made any false statement or fraudulent representation on any form submitted to the State Agency or the Secretary may be prosecuted under applicable Federal or state laws;
7. That the provider understands it is their responsibility to ensure that all information is continuously kept up to date on the Louisiana Medicaid Provider File;
8. That the provider understands that the failure to maintain current and correct information may result in payments being delayed or closure of this Medicaid provider number;
9. That the provider understands if this number is closed due to inaccurate information or inactivity, they will have to complete a new Provider Enrollment Packet in its entirety for consideration to reactivate this provider number;
10. The provider understands that under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. *(See Federal Regulations 42 CFR § 455.104(b)(1).* A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. *(See Federal Regulations 42 CFR § 455.104(b)(2).* Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest.
11. That the provider understands that as part of the Louisiana Medicaid enrollment/re-enrollment process, pursuant to Louisiana Medicaid Rules and Regulations, they must provide Social Security numbers for each of the following persons:
    - All Individuals with Direct or Indirect Ownership or Control Interest of 5% or more;
    - All Individuals acting as Board of Director;
    - All Individual Corporate Officers, Directors, Partners, or Shareholders;
    - All Individual Managing Employees or Agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day to day operations.
12. I attest that I am a United States citizen or have legal status and work privilege in the US.
13. The provider understands that it is their responsibility to ensure that all managing employees, employees, agents, affiliates or subcontractors are U.S. Citizens or have legal status and work privilege in the U.S.
14. The provider understands that it is their responsibility to ensure that it is disclosed on this form if any Owner, Board Member, Corporate Officer, Partner, Board of Director, Shareholder, Managing employee, Employee, Agent or Affiliate, have ever:
    - been denied enrollment from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been terminated from participation from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been employed by a corporation, business or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program in any state; or
    - been convicted of any crimes.
15. The provider understands that pursuant to 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2), they are required to provide certain data pertaining to subcontractors within 35 calendar days of the date of the request.
16. The provider understands that they shall report any of the above conditions to the Louisiana Department of Health (LDH). Once enrolled, the provider understands that upon discovery of any of the above conditions, it is their responsibility to report immediately in writing to LDH, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821-9030.
17. I understand if I answered "Yes" to questions regarding being convicted of a felony or any criminal offense, or if I have ever had any disciplinary action taken against my professional license (board actions, board consent order, restriction, suspension, revocation or voluntary surrender to avoid disciplinary action), or if I have ever been denied enrollment or been excluded, terminated from participation, suspended, or voluntarily withdrawn to avoid disciplinary action from any Federally funded healthcare program, I am required to submit this information and the requested documentation.
18. The provider understands that they are being placed on notice of Louisiana state law, R.S. 14:126.3.1 entitled "Unauthorized participation in medical assistance programs." The provider understands that this criminal statute means that if any owners, managing employees, employees, agents, affiliates, or subcontractors, are excluded now or become excluded in the future or have been terminated from participation in the Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, it is a crime to "participate" in any medical assistance program. The provider also understands that "participation" includes providing any services which will be billed, directly or indirectly, to Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, and "participation" also includes to seek or to be employed, directly or by contract, or have an ownership interest in any individual or entity that provides such services which will be billed to these programs. The provider also understands that this crime can be punishable as a felony for up to five (5) years imprisonment with or without hard labor, as well as a maximum fine of $20,000.00. I also understand that any claims for payment with a date of service during a period of exclusion will be subject to recoupment in addition to other fines, penalties, or restitution resulting from the criminal prosecution (LA R.S. 14.126.3.1).

Carlos Lacasa
Printed Name of Authorized Representative

Signature of Authorized Representative
(sign in blue ink)

Senior Vice President and General Counsel
Title/Position of Authorized Representative

March 29, 2019
Date of Signature

State of Louisiana

UNION JUSTICE AND CONFIDENCE

James J. Donelon

COMMISSIONER OF INSURANCE

CETIFICATE OF AUTHORITY

Whereas, MCNA Insurance Company located in Texas has applied for a certificate of authority and made the filings required of such Insurer. Therefore, I, James Donelon, the undersigned Commissioner of Insurance, do hereby certify that the said MCNA Insurance Company is authorized to transact its appropriate business of Health and accident Insurance in this state, in accordance with the laws thereof. This certificate shall remain in effect until cancelled, suspended, revoked or the renewal thereof refused.

In Testimony Whereof, I hereunto subscribe my name,

and affix the seal of my office at Baton Rouge this

26th day of December A.D. 2012

James J. Donelon
Commissioner of Insurance