Office of State Procurement
Contract Certification of Approval

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

Reference Number: 2000506243

Amendment Number: 2

Vendor: MCNA INSURANCE COMPANY

Description: MCNA Insurance Co

Approved By: PAMELA RICE

Approval Date: 06/25/2021 18:11:53

Rev 2019-12

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

MVA

(Regional/ Program/ Facility)

Medical Vendor Administration

Bureau of Health Services Financing

AND

MCNA Insurance Company, d/b/a MCNA Dental

Contractor Name

Amendment #: 2

LAGOV#: 2000506243

LDH #:

Original Contract Amount: $355,700,072.00

Original Contract Begin Date: 01-01-2021

Original Contract End Date: 12-31-2023

RFP Number: 3000013043

AMENDMENT PROVISIONS

Change Contract From: Current Maximum Amount: $355,700,072.00 Current Contract Term: 1/1/2020 - 12/31/2023

Attachment B - Statement of Work

Change Contract To: If Changed, Maximum Amount: If Changed, Contract Term:

Attachment B2 - Changes to Statement of Work

Justifications For Amendment:

Revisions contained in this amendment are within scope and comply with the terms and conditions as set forth in the RFP.

These revisions will align the DBPM contracts with the managed care final rule, the Interoperability and Patient Access final rule, current reporting requirements, and other LDH contracting standards.

This Amendment Becomes Effective: 01-01-2021

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

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

CONTRACTOR

MCNA Insurance Company, d/b/a MCNA Dental

CONTRACTOR SIGNATURE: DocuSigned by: Thomas Wiffler 486524F1737B4AA... DATE: 6/4/2021

PRINT NAME: Tom Wiffler

CONTRACTOR TITLE: CEO

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

SIGNATURE: DocuSigned by: Tara A LeBlanc 3AB1483AD9604E0... DATE: 6/7/2021

NAME: Tara LeBlanc

TITLE: Interim Medicaid Executive Director

OFFICE: Louisiana Department of Health

PROGRAM SIGNATURE DATE

NAME

DBPM Contract Amendment #2
Attachment B-2

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
1	Attachment B Statement of Work	2.5.4.11 The DBPM shall comply with the following standards, measured on a monthly basis, for processing authorization requests in a timely manner: 2.5.4.11.1 The DBPM shall process ninety-five percent (95%) of all standard authorizations within ten (10) calendar days and one hundred percent (100%) in fourteen (14) days. 2.5.4.11.2 The DBPM shall process ninety-five percent (95%) of all expedited authorizations within two (2) business days and one hundred percent (100%) in three (3) calendar days.	2.5.4.11 The DBPM's service authorization system shall process and track service authorizations to ~~shall~~ comply with the ~~following~~ standards established in this Contract.~~, measured on a monthly basis, for processing authorization requests in a timely manner:~~ ~~2.5.4.11.1 The DBPM shall process ninety-five percent (95%) of all standard authorizations within ten (10) calendar days and one hundred percent (100%) in fourteen (14) days.~~ ~~2.5.4.11.2 The DBPM shall process ninety-five percent (95%) of all expedited authorizations within two (2) business days and one hundred percent (100%) in three (3) calendar days.~~	This revision removes duplication by referring to Section 2.5.7 for service authorization standards.
2		2.5.7.2 The DBPM shall comply with the following standards, measured on a monthly basis, for notifying providers and enrollees in a timely manner: 2.5.7.2.1 The DBPM shall provide standard authorization decisions within no more than fourteen (14) calendar days following receipt of the request for service. 2.5.7.2.2 The DBPM may extend the timeframe for standard authorization decisions up to fourteen (14) additional calendar days, if the enrollee or the provider requests extension, or the DBPM justifies the need for additional information and how the extension is in the enrollee's interest. 2.5.7.2.3 The DBPM shall provide expedited authorization decisions within no later than seventy-two (72) hours following receipt of the request for service. 2.5.7.2.4 The DBPM may extend the timeframe for expedited authorization decisions up to fourteen (14) additional calendar	2.5.7.2 The DBPM shall comply with the following standards, measured on a monthly basis, for processing service authorizations and notifying providers and enrollees in a timely manner: 2.5.7.2.1 The DBPM shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information regarding a proposed procedure or service requiring a review determination. All ~~provide~~ standard authorization decisions shall be made within no more than ~~fourteen~~ (14) calendar days following receipt of the request for service. 2.5.7.2.2 The DBPM may extend the timeframe for standard authorization decisions up to fourteen (14) additional calendar days, if the enrollee or the provider requests extension, or the DBPM justifies the need for additional information and how the extension is in the enrollee's interest. 2.5.7.2.3 In the event a provider indicates, or the DBPM determines, that following the standard service authorization timeframe could	These revisions align the DBPM service authorization standards with MCO contracts and current reporting requirements.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		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.	seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function, the ~~The~~ DBPM shall provide an expedited authorization decision~~s~~ as expeditiously as the enrollee's health condition requires, but ~~within~~ no later than seventy-two (72) hours following receipt of the request for service. 2.5.7.2.4 The DBPM may extend the timeframe for expedited authorization decisions up to fourteen (14) additional calendar days, if the enrollee or the provider requests extension, or the DBPM justifies the need for additional information and how the extension is in the enrollee's interest.	
3	Attachment B Statement of Work	2.6.2.6 The DBPM shall comply with the following maximum distance requirements, as determined by mapping software (e.g. MapQuest, Google Maps, ArcGIS). Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval. 2.6.2.6.1 Distance to Primary Dental Services Travel distance from enrollee's place of residence shall not exceed thirty (30) miles or sixty (60) minutes one-way for rural areas and ten (10) miles or twenty (20) minutes for urban areas. 2.6.2.6.2 Distance to Specialty Dental Services Travel distance shall not exceed sixty (60) miles one-way from the enrollee's place of residence for at least seventy-five (75) percent of enrollees and shall not exceed ninety (90) minutes one-way from the enrollee's place of residence for all enrollees.	2.6.2.6 The DBPM shall comply with the following maximum distance requirements, as determined by mapping software (e.g. MapQuest, Google Maps, ArcGIS). Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval. 2.6.2.6.1 Distance to Primary Dental Services Travel distance from enrollee's place of residence shall not exceed thirty (30) miles ~~or sixty (60) minutes~~ one-way for rural areas and ten (10) miles ~~or twenty (20) minutes~~ one way for urban areas. 2.6.2.6.2 Distance to Specialty Dental Services Travel distance shall not exceed sixty (60) miles one-way from the enrollee's place of residence for at least seventy-five (75) percent of enrollees and shall not exceed ninety (90) miles ~~minutes~~ one-way from the enrollee's place of residence for all enrollees.	These revisions remove the time standard from the geographic access requirements, as allowed by the managed care final rule published on November 13, 2020, which revised 42 CFR §438.68(b)(1) and (2) by deleting the requirements for states to set time and distance standards and adding a more flexible requirement that states set a quantitative network adequacy standard.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
4	Attachment B Statement of Work	2.6.11.2 The DBPM shall notify the DBPM enrollees that their primary dental care provider's provider agreement has been terminated. Notice shall be sent within thirty (30) calendar days after issuance of the termination notice to the provider. This notice shall include a list of recommended network providers available to the enrollee in their surrounding area. 2.6.11.3 The DBPM shall provide notice to an enrollee, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within ten (10) calendar days from the date the DBPM becomes aware of such, if it is prior to the change occurring.	2.6.11.2 The DBPM shall notify the DBPM enrollees that their primary dental care provider's provider agreement has been terminated. Notice shall be sent by the later of ~~within~~ thirty (30) calendar days prior to the effective date of the termination, or fifteen (15) calendar days after receipt or issuance of the termination notice ~~to the provider~~. This notice shall include a list of recommended network providers available to the enrollee in their surrounding area. 2.6.11.3 The DBPM shall provide notice to an enrollee, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. ~~The written notice shall be provided within ten (10) calendar days from the date the DBPM becomes aware of such, if it is prior to the change occurring.~~	These revisions conform to the managed care final rule published on November 13, 2020 which revised information requirements in 42 CFR §438.10.
5	Attachment B Statement of Work	2.7.2.3 The provider service component of the toll-free telephone line must have the capability to track metrics substantially similar to those of the enrollee help line.	2.7.2.3 The provider service component of the toll-free telephone line shall comply with the enrollee call center performance standards outlined in Section 2.9.10 and must have the capability to track metrics that align with those standards, at a minimum ~~substantially similar to those of the enrollee help line~~.	These revisions align the provider and enrollee call center performance standards to current reporting metrics.
6	Attachment B Statement of Work	2.9.2.1.2.1 In accordance with 42 CFR §438.10(h), the DBPM must develop and implement an online provider directory, to be approved by LDH. The directory shall be interactive and user friendly and updated no less than once weekly. The provider directory shall include the following information: …	2.9.2.1.2.1 In accordance with 42 CFR §438.10(h), the DBPM must develop and implement an online provider directory, to be approved by LDH. The directory shall be interactive and user friendly, web-based machine searchable, web-based machine readable, and mobile-enabled. It must be accurate, complete, and updated no less than once weekly. The provider directory shall include the following information: …	These revisions to provider directory conform to the managed care final rule published on November 13, 2020 which revised information requirements in 42 CFR §438.10.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		2.9.2.1.2.2 The DBPM shall update the printable version of the provider directory at least monthly and include versioning. … 2.9.8.3.4 The DBPM shall maintain an accurate and complete online provider directory containing all the information required in the printed provider directory. The online directory shall be made available in a machine-readable file and format in compliance with federal regulations.	2.9.2.1.2.2 The DBPM shall update the printable version of the provider directory at least quarterly ~~monthly~~ and include versioning. … ~~2.9.8.3.4 The DBPM shall maintain an accurate and complete online provider directory containing all the information required in the printed provider directory. The online directory shall be made available in a machine-readable file and format in compliance with federal regulations.~~ (subsequent provisions renumbered)	
7	Attachment B Statement of Work	2.9.2.1.3.2.4 Written material must also be made available in alternative formats upon request of the enrollee at no cost. Auxiliary aids such as TTY/TTD and American Sign Language (ASL) and services must also be made available upon request of the enrollee at no cost. Written materials must include taglines in the prevalent non-English languages, as well as large print, explaining the availability of written translation or oral interpretation to understand the information. Large print means printed in a font size no smaller than 18 point.	2.9.2.1.3.2.4 Written material must also be made available in alternative formats upon request of the enrollee at no cost. Auxiliary aids such as TTY/TTD and American Sign Language (ASL) and services must also be made available upon request of the enrollee at no cost. Written materials critical to obtaining services, including information on how to request auxiliary aids and services, must include taglines in the prevalent non-English languages, as well as large print, explaining the availability of written translation or oral interpretation to understand the information. Large print means printed in a ~~font size no smaller than 18 point~~ conspicuously-visible font size.	These revisions conform to the managed care final rule published on November 13, 2020 which revised information requirements in 42 CFR §438.10.
8	Attachment B Statement of Work	2.9.10.9 The DBPM shall develop performance standards and monitor enrollee help line performance by recording calls and employing other monitoring activities. Such standards shall be submitted to and approved by LDH before use, and comply with monetary penalties outlined in the Contract. The DBPM shall report	2.9.10.9 The DBPM shall develop performance standards and monitor enrollee help line performance by recording calls and employing other monitoring activities. Such standards shall be submitted to and approved by LDH before use, and comply with monetary penalties outlined in the Contract. The DBPM shall report its performance on these standards. These standards shall be	These revisions correct an unintentional omission from the contract and align the enrollee call center performance standards with existing reporting metrics.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		its performance on these standards. These standards shall be measured on a monthly basis and, at a minimum, require that: 2.9.10.9.1 The average speed to answer shall not exceed thirty (30) seconds. 2.9.10.9.2 The call blockage rate for direct calls shall not exceed one-half of one percent (.05%). 2.9.10.9.3 The average call abandonment rate shall not exceed three percent (3%). A system which places calls in a queue may be used, but the average wait time in the queue shall not exceed sixty (60) seconds.	measured on a monthly basis and, at a minimum, require that the system: 2.9.10.9.1 Answer ninety-five percent (95%) of calls within thirty (30) seconds or direct the call to an automatic call pickup system with IVR options; 2.9.10.9.2 No more than one percent (1%) of incoming calls receive a busy signal; 2.9.10.9.3 Maintain an average hold time of three (3) minutes or less per call. Hold time, or wait time, for the purposes of this Contract includes 1) the measure of time after a caller has requested a live person through the IVR system and before a customer service representative answers the call; plus 2) the measure of time when a customer service representative places a caller on hold. 2.9.10.9.4 Maintain a call abandonment rate of not more than five percent (5%). ~~2.9.10.9.1 The average speed to answer shall not exceed thirty (30) seconds.~~ ~~2.9.10.9.2 The call blockage rate for direct calls shall not exceed one-half of one percent (.05%).~~ ~~2.9.10.9.3 The average call abandonment rate shall not exceed three percent (3%). A system which places calls in a queue may be used, but the average wait time in the queue shall not exceed sixty (60) seconds.~~	

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
9	Attachment B Statement of Work	2.10.3 Standard Resolution of Appeals 2.10.3.1 The DBPM shall adhere to the following timeframes for processing appeals: 2.10.3.1.1 An enrollee, authorized representative, or legal representative of the estate may file an appeal orally or in writing within sixty (60) calendar days from the date on the notice of adverse benefit determination. 2.10.3.1.2 Once an oral appeal is received: 2.10.3.1.2.1 The DBPM shall notify the enrollee verbally that a written confirmation is required for the appeal process to continue. The DBPM should inform the enrollee they will be receiving a notice for written confirmation of the appeal. 2.10.3.1.2.2 The DBPM will send a notice to the enrollee, acknowledging the oral appeal request was received and written confirmation is required. This notice must contain the timeframe for receipt of the written confirmation and future actions. 2.10.3.1.2.3 The DBPM will provide a form for the enrollee to sign and send back, as well as the options available for receipt of written confirmation (fax, email, regular postal mail). 2.10.3.1.2.4 The enrollee has fifteen (15) days from the date of the notice to send their written confirmation. 2.10.3.1.2.5 If written confirmation is not received within the fifteen (15) day timeframe:	2.10.3 Standard Resolution of Appeals 2.10.3.1 The DBPM shall adhere to the following timeframes for processing appeals: 2.10.3.1.1 An enrollee, authorized representative, or legal representative of the estate may file an appeal, orally or in writing, within sixty (60) calendar days from the date on the notice of adverse benefit determination. 2.10.3.1.2 Once an oral appeal is received, the DBPM shall inform the enrollee they shall receive a notice or written confirmation of the appeal.~~:~~ ~~2.10.3.1.2.1 The DBPM shall notify the enrollee verbally that a written confirmation is required for the appeal process to continue. The DBPM should inform the enrollee they will be receiving a notice for written confirmation of the appeal.~~ ~~2.10.3.1.2.2 The DBPM will send a notice to the enrollee, acknowledging the oral appeal request was received and written confirmation is required. This notice must contain the timeframe for receipt of the written confirmation and future actions.~~ ~~2.10.3.1.2.3 The DBPM will provide a form for the enrollee to sign and send back, as well as the options available for receipt of written confirmation (fax, email, regular postal mail).~~ ~~2.10.3.1.2.4 The enrollee has fifteen (15) days from the date of the notice to send their written confirmation.~~	These revisions conform to the managed care final rule published on November 13, 2020 which eliminates the requirement for enrollees to submit a written, signed appeal after an oral appeal is submitted. [Refer to 42 CFR §438.402(c)(3)(ii) and §438.406(b)(3).]

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		2.10.3.1.2.5.1 The DBPM will close the appeal as incomplete for non-receipt of written confirmation. 2.10.3.1.2.5.2 The DBPM will send a notification to the enrollee of the appeal closure. This notice must consist of the reason for the incomplete appeal and inform the enrollee that they may submit a new appeal if they are within the original sixty (60) days of the adverse action. This closure does not escalate the appeal to a State Fair Hearing since the initial appeal process was not been completed. 2.10.3.1.2.6 Once a request for an oral appeal has been closed for non-receipt of a written confirmation, a new appeal date can be established with an oral or written appeal request if it is within the original sixty (60) days of the adverse action. 2.10.3.1.3 Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The DBPM must inform the enrollee of the limited time available for this in the case of expedited resolution.	~~2.10.3.1.2.5 If written confirmation is not received within the fifteen (15) day timeframe:~~ ~~2.10.3.1.2.5.1 The DBPM will close the appeal as incomplete for non-receipt of written confirmation.~~ ~~2.10.3.1.2.5.2 The DBPM will send a notification to the enrollee of the appeal closure. This notice must consist of the reason for the incomplete appeal and inform the enrollee that they may submit a new appeal if they are within the original sixty (60) days of the adverse action. This closure does not escalate the appeal to a State Fair Hearing since the initial appeal process was not been completed.~~ ~~2.10.3.1.2.6 Once a request for an oral appeal has been closed for non-receipt of a written confirmation, a new appeal date can be established with an oral or written appeal request if it is within the original sixty (60) days of the adverse action.~~ 2.10.3.1.3 Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The DBPM must inform the enrollee of the limited time available for this in the case of expedited resolution.	
10	Attachment B Statement of Work	2.10.6.1 An enrollee or authorized representative, who has completed the DBPM's appeal process, may request a state fair hearing after receiving a notice of appeal resolution indicating that the DBPM is upholding, in whole or in part, the adverse benefit determination, or after the DBPM fails to adhere to the notice and timing requirements applicable to appeals.	2.10.6.1 An enrollee or authorized representative, who has completed the DBPM's appeal process, may request a state fair hearing within one hundred twenty (120) calendar days after receiving a notice of appeal resolution indicating that the DBPM is upholding, in whole or in part, the adverse benefit determination, or after the DBPM fails to adhere to the notice and timing requirements applicable to appeals.	This revision conforms to the managed care final rule published on November 13, 2020 which requires the timeframe for an enrollee to request a state fair hearing to be no less than 90 calendar days and no more than 120 calendar days from the date of the DBPM's notice of resolution. [Refer to 42 CFR §438.408(f)(2).]

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
11	Attachment B Statement of Work	2.10.6.4 The DBPM shall submit an evidence packet to LDH and to the enrollee, free of charge, within ten (10) business days from the time the DBPM receives notification of the hearing. The evidence packet must be submitted to LDH in accordance with any prehearing instructions. The evidence packet must include all necessary documents including the statement of matters (or, alternatively, the denial letter) and any dental records or other documents and/or records considered or relied upon by the DBPM and supporting the DBPM's adverse benefit determination and appeal resolution.	2.10.6.4 The DBPM shall submit an evidence packet to LDH and to the enrollee, free of charge, within seven (7) ~~ten (10)~~ business days from the time the DBPM receives notification of the hearing. The evidence packet must be submitted to LDH in accordance with any prehearing instructions. The evidence packet must include all necessary documents including the statement of matters (or, alternatively, the denial letter) and any dental records or other documents and/or records considered or relied upon by the DBPM and supporting the DBPM's adverse benefit determination and appeal resolution.	This correction aligns with the Memorandum of Understanding with the Division of Administrative Law.
12	Attachment B Statement of Work	(new provision)	2.13.13 CMS Interoperability and Patient Access The DBPM shall comply with the CMS Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issues of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers (referred to as the "CMS Interoperability and Patient Access final rule") in accordance with timelines established by CMS and as directed by LDH through the LDH MCE Interoperability Compliance Plan.	This provision addresses DBPM compliance of the Interoperability and Patient Access final rule and directs the DBPMs to the LDH MCE Interoperability Compliance Plan for specific direction on compliance as mandated by LDH.
13	Attachment B Statement of Work	2.14.3.1.3 Within five (5) business days of receipt of a claim, the DBPM shall perform an initial screening, and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication. 2.14.3.1.4 The DBPM shall fully adjudicate (pay or deny) all pended claims within sixty (60) calendar days of the date of receipt.	2.14.3.1.3 Within five (5) business days of receipt of a claim, the DBPM shall perform an initial screening, and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication. 2.14.3.1.4 The DBPM shall process and pay or deny, as appropriate, at least ninety percent (90%) of all clean claims for	These revisions correct an unintentional omission from the contract and provide additional claims processing standards for clean claims which align with the MCO contracts.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			each claim type, within fifteen (15) business days of the date of receipt. 2.14.3.1.5 The DBPM shall process and pay or deny, as appropriate, one hundred percent (100%) of all clean claims for each claim type, within thirty (30) calendar days of the date of receipt. 2.14.3.1.6 The DBPM shall fully adjudicate (pay or deny) all pended claims within sixty (60) calendar days of the date of receipt.	
14	Attachment B Statement of Work	2.14.11.3 The DBPM shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided.	2.14.11.3 The DBPM shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided. 2.14.11.4 The DBPM shall comply with the required format provided by LDH. Encounter data includes claims paid or denied by the DBPM or the DBPM's subcontractors for services delivered to enrollees through the DBPM during a specified reporting period. Submissions must include, at a minimum, all enrollee encounter data, including allowed amount and paid amount, that the State is required to report to CMS. LDH collects and uses this data for many reasons such as: federal reporting, rate setting, risk adjustment, service verification, managed care quality improvement program, utilization patterns and access to care. (subsequent provisions renumbered)	This revision is to comply with the managed care final rule published on November 13, 2020 which requires DBPMs to submit to the state the same encounter data that is submitted in T-MSIS submissions to CMS, including allowed amount and paid amount. [Refer to 42 CFR § 438.242(c)(3).]
15	Attachment B	3.6.5 Table of Monetary Penalties Number: 14	3.6.5 Table of Monetary Penalties Number: 14	This revision corrects an unintentional omission from the contract and provides specific monetary

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
	Statement of Work	Requirement: Failure to comply with provider payment requirements specified in the Contract. Monetary Penalty: $7,500 per day, per occurrence.	Requirement: Failure to comply with provider payment requirements specified in the Contract, including:~~.~~ Ninety percent (90%) of all clean claims must be paid within fifteen (15) business days of the date of receipt. One hundred 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 twelve percent (12%) per annum, calculated daily for the full period in which the clean claim remains unadjudicated beyond the thirty (30) calendar day claims processing deadline. Interest owed the provider must be paid the same date that the claim is adjudicated. Monetary Penalty: ~~$7,500 per day, per occurrence.~~$5,000 for the first quarter that the DBPM's claims performance percentages by claim type fall below the performance standard. $25,000 per quarter for each additional quarter that the DBPM's claims performance percentages by claim type fall below the performance standards. $1,000 per claim if the DBPM fails to timely pay interest.	penalties to align with the claims processing requirements as amended.
16	Attachment B Statement of Work	3.6.5 Table of Monetary Penalties Number: 21 Requirement: Failure to submit any complete and/or accurate report specified in the Contract.	3.6.5 Table of Monetary Penalties Number: 21 Requirement: Failure to submit any complete and/or accurate standing or ad hoc report ~~specified~~ in accordance with the Contract.	This revision clarifies that the monetary penalty applies to both standing and ad hoc reports and aligns with the MCO contracts.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		Monetary Penalty: $2,500 per day, per occurrence.	Monetary Penalty: $2,500 per day, per occurrence.	
17	Attachment B Statement of Work	3.6.5 Table of Monetary Penalties (new item)	3.6.5 Table of Monetary Penalties Number: 24 Requirement: Failure to comply with enrollee help line performance standards. Monetary Penalty: $10,000 per calendar day for failure to operate a toll-free number that is available to enrollees twenty-four (24) hours a day, seven (7) days a week. $1,000 for each percentage point for each standard that fails to meet the requirements for a monthly reporting period. Standard rounding will be applied. $1,000 for each 30 second time increment, or portion thereof, by which the DBPM's average hold time exceeds the maximum acceptable hold time for a monthly reporting period.	This revision corrects an unintentional omission from the contract and provides specific monetary penalties for failure to comply with enrollee help line performance standards specified in the contract.
18	Attachment B Statement of Work	3.6.5 Table of Monetary Penalties (new item)	3.6.5 Table of Monetary Penalties Number: 25 Requirement: Failure to comply with provider help line performance standards. Monetary Penalty: $10,000 per calendar day for failure to operate a toll-free number that is available to providers twenty-four (24) hours a day, seven (7) days a week.	This revision corrects an unintentional omission from the contract and provides specific monetary penalties for failure to comply with provider help line performance standards specified in the contract.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			$1,000 for each percentage point for each standard that fails to meet the requirements for a monthly reporting period. Standard rounding will be applied. $1,000 for each 30 second time increment, or portion thereof, by which the DBPM's average hold time exceeds the maximum acceptable hold time for a monthly reporting period.	
19	Attachment B Statement of Work	(new provision)	3.6.9 Notices of Action 3.6.9.1. LDH may first notify the DBPM of incidents of non-compliance and of LDH's authority to impose a monetary penalty via a Notice of Action (NOA). The NOA will include the basis and nature of the violation, the relevant section(s) of the Contract and/or provision(s) of law, the deadline to cure the violation, if applicable, and the methodology for calculation of any monetary penalty if the violation is not cured by the deadline, if applicable. 3.6.9.2. LDH may require the DBPM to provide a written response with a detailed explanation of the reasons for the violation, the DBPM's assessment or diagnosis of the cause, and DBPM's plan to address or cure the violation within the timeframe set forth in the NOA. 3.6.9.3. Repeated deficiencies or the repeated failure to resolve any such deficiencies may entitle LDH to pursue any other remedy provided in the Contract or any other appropriate remedy available under law. 3.6.9.4. At any time and at its sole discretion, LDH may impose or pursue one or more remedies for each item of noncompliance and will determine appropriate remedies on a case-by-case basis.	These new provisions formalize the process for issuing NOAs and NMPs and establish a formal process and timeline for resolving disputes and appeals of non-compliance actions to align with the MCO contracts.

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			3.6.10 Notices of Monetary Penalty Monetary penalties may be assessed against the DBPM at the sole discretion of LDH, regardless of whether an NOA is issued. LDH will notify the DBPM of the assessment of monetary penalties via a Notice of Monetary Penalty (NOMP). 3.6.11 Disputes and Appeals 3.6.11.1 If LDH chooses to notify the DBPM of incidents of non-compliance and of LDH's authority to impose a monetary penalty via a NOA prior to assessing the penalty or sanction, the DBPM may dispute infractions contained within the NOA through the following process: 3.6.11.1.1 Within fourteen (14) calendar days after the date of receipt of the NOA, the DBPM shall submit its dispute of the NOA in writing via e-mail to the Medicaid Deputy Director or his/her designee; this submission shall include all arguments, materials, data, and information necessary to resolve the dispute. 3.6.11.1.2 The DBPM shall waive any dispute or argument not raised within fourteen (14) calendar days of the date of receipt of the NOA. The DBPM shall also waive the right to use any materials, data, and/or information not contained in or accompanying the DBPM's dispute submitted within the fourteen (14) calendar days following its receipt of the NOA in any subsequent NOMP issued should the DBPM fail to demonstrate compliance as stated in the NOA. 3.6.11.1.3 The Medicaid Deputy Director or his/her designee will issue a written decision. This written decision will be final.	

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			3.6.11.2 To appeal the assessment of a monetary penalty or intermediate sanction: 3.6.11.2.1 Within seven (7) business days of the date of receipt of the NOMP, the DBPM shall submit its appeal in writing to the Medicaid Deputy Director or his/her designee. The Medicaid Deputy Director or his/her designee will issue a written decision within fifteen (15) business days after the date of receipt of the appeal. 3.6.11.2.2 Within five (5) business days after the date of receipt of LDH's written decision, the DBPM may request reconsideration of the decision in writing to the LDH Medicaid Director. The LDH Medicaid Director shall issue a written decision within thirty (30) calendar days after the date of receipt of the request for reconsideration. No further appeals to LDH shall be allowed.	
20	Attachment B Statement of Work	4.2.1 LDH will develop cost-effective and actuarially sound rates according to all applicable CMS rules and regulations. LDH will not use a competitive bidding process to develop the DBPM capitation. LDH will develop monthly capitation rates that will be offered to the DBPM on a "take it or leave it" basis. … 4.2.4 Any adjusted rate must continue to be actuarially sound and consistent with requirements set forth in 42 CFR §438.6(c), and will require an amendment to the Contract. 4.2.5 Additional factors determining the rate for an individual member may include: 1) age; 2) gender; 3) Medicaid category of assistance; 4) the geographic location of the member's residence; and 5) Medicare enrollment.	4.2.1 LDH will develop cost-effective and actuarially sound rates ~~according to~~ in accordance with 42 CFR §438.4 through §438.7 and all applicable CMS rules and regulations. LDH will not use a competitive bidding process to develop the DBPM capitation. LDH will develop monthly capitation rates that will be offered to the DBPM on a "take it or leave it" basis. … ~~4.2.4 Any adjusted rate must continue to be actuarially sound and consistent with requirements set forth in 42 CFR §438.6(c), and will require an amendment to the Contract.~~ 4.2.~~4~~5 Additional factors determining the rate for an individual member may include: 1) age; 2) gender; 3) Medicaid category of assistance; 4) the geographic location of the member's residence; and 5) Medicare enrollment.	These revisions provide flexibility to utilize the additional options related to rate development established by the managed care final rule published on November 13, 2020. Revisions also remove duplication.

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		4.2.6 The rates will be reviewed and may be periodically adjusted. Any adjusted rates shall be actuarially sound and consistent with requirements set forth in 42 CFR §438.6(c). 4.2.7 The DBPM shall provide in writing any information requested by LDH to assist in the determination of DBPM rates. LDH will give the DBPM reasonable time to respond to the request and full cooperation by the DBPM is required. LDH will make the final determination as to what is considered reasonable.	4.2.56 The rates will be reviewed and may be periodically adjusted. Any adjusted rates shall be actuarially sound, ~~and~~ consistent with requirements set forth in 42 CFR ~~§438.6(c)~~§438.4 through §438.7, and will require an amendment to the Contract. 4.2.67 The DBPM shall provide, in writing, any information requested by LDH to assist in the determination of DBPM rates. LDH will give the DBPM reasonable time to respond to the request, and full cooperation by the DBPM is required. LDH will make the final determination as to what is considered reasonable.	
21	Attachment B Statement of Work	(new provision)	4.7 Other Payment Terms Should any part of the scope of work under this Contract relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the DBPM must do no work on that part after the effective date of the loss of program authority. The State must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the DBPM works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the DBPM will not be paid for that work. If the State paid the DBPM in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the State. However, if the DBPM worked on a program or activity prior to the date legal authority ended for that program or activity, and the State included the cost of performing that work in its payments to the DBPM, the DBPM may keep the payment for that work even if	This addition is a CMS requirement to address situations where managed care activities have been vacated by a court. CMS issued this guidance as part of their ongoing effort to provide states greater transparency and consistency across CMS' managed care plan contract review process.

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<tr><th>Item Number</th><th>Exhibit/ Attachment/ Document</th><th>Change From:</th><th>Change To:</th><th>Justification</th></tr>
<tr><td></td><td></td><td></td><td>the payment was made after the date the program or activity lost legal authority.</td><td></td></tr>
<tr><td>22</td><td>Attachment B

Statement of Work</td><td>7.1 Glossary
…<table><tr><td>Adverse Benefit Determination</td><td>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.</td></tr></table></td><td>7.1 Glossary
…<table><tr><td>Adverse Benefit Determination</td><td>Means any of the following:
• The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
• The reduction, suspension, or termination of a previously authorized service.
• The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a ‘‘clean claim’’ in accordance with 42 CFR §447.45(b) is not an adverse benefit determination.
• The failure to provide services in a timely manner, as defined by the State.
• The failure of a DBPM to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the</td></tr></table></td><td>This revision is to comply with the managed care final rule published on November 13, 2020 which clarifies that a denial due solely to not meeting the definition of a clean claim is not an adverse benefit determination and is therefore not subject to the notice requirements of 42 CFR §438.404. [Refer to 42 CFR §438.400(b)(3).]

These revisions also improve the formatting of the definition and remove provisions that are not applicable.</td></tr>
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			standard resolution of grievances and appeals. ~~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.~~	