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: 2000683487

Amendment Number: 12

Vendor: AETNA BETTER HEALTH INC LA

Description: Managed Care Organizations 3.0

Approved By: PAMELA RICE

Approval Date: 12/23/2025 13:05:51

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

MVA

Medical Vendor Administration

(Regional/ Program/ Facility)

Bureau of Health Services Financing

AND

Aetna Better Health of Louisiana, Inc.

Contractor Name

Amendment #: 12
LAGOV#: 2000683487
LDH #:
Original Contract Amount
Original Contract Begin Date 01-01-2023
Original Contract End Date 12-31-2025
RFP Number: 3000017417

AMENDMENT PROVISIONS

Change Contract From: Current Maximum Amount: Current Contract Term : 01/01/23-12/31/25

CF-1
11) Termination Date: 12/31/2025
12) Maximum Contract Amount: $3,874,496,959.00
13) Estimated Amounts by Fiscal Year: FY23: $588,884,043; FY24: $1,273,098,619; FY25: $1,324,022,564; FY26: $688,491,733.00
15) Attachments and Exhibits:
Attachment A11 - Model Contract; Attachment C10, In Lieu of Services (ILOS)
Attachment F10 - Provider Network Standards; Attachment G11, Table of Monetary Penalties

Change Contract To: If Changed, Maximum Amount: If Changed, Contract Term: 01/01/23-12/31/26

CF-1
11) Termination Date: 12/31/2026
12) Maximum Contract Amount: $5,773,366,768.00
13) Estimated Amounts by Fiscal Year: FY23: $588,884,043; FY24: $1,273,098,619; FY25: $1,324,022,564;
FY26: $1,615,068,572; FY27: $972,292,970
15) Attachments and Exhibits:
Attachment A12 - Model Contract; Attachment C12, In Lieu of Services (ILOS), Attachment F12 - Provider Network Standards;
Attachment G12, Table of Monetary Penalties

Justifications For Amendment:

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

This amendment contains necessary revisions for several attachments in order to align with all provisions of state and federal laws, regulations, rules, the State Plan, waivers applicable to managed care, and current practice.

LDH is extending the contract for twelve (12) additional months at the same rates, terms, and conditions of the initial contract term. This amendment extends the contract through December 31, 2026.

This Amendment Becomes Effective: 01-01-2026

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

Aetna Better Health of Louisiana, Inc.

Signed by: Brit Dear
2EE41ED62B8D489

CONTRACTOR SIGNATURE 12/2/2025 DATE

PRINT NAME: Bridget Galatas

CONTRACTOR TITLE: Chief Executive Officer

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

SIGNATURE DATE 12/17/25

NAME: Bruce D. Greenstein

TITLE: Secretary

OFFICE: Louisiana Department of Health

DocuSigned by: Drew Maranto

PROGRAM SIGNATURE 12/11/2025 DATE

NAME: Drew Maranto

LOUISIANA DEPARTMENT OF HEALTH

MCO Amendment 12
Attachment A12 – Changes to Attachment A, *Model Contract*

Item	Change From	Change To	Justification
1	**Glossary** **[…]** **Care Coordination** – Deliberate organization of patient care activities by a person or entity, including the Contractor that is formally designated as primarily responsible for coordinating services furnished by providers involved in the Enrollee's care, to facilitate the appropriate delivery of health care services. Care coordination activities may include but aren't limited to the coordination of specialty referrals, assistance with Ancillary Services, and referrals to and coordination with community services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of the Enrollee's care.	**Glossary** **[…]** **Care Coordination –** Deliberate organization of patient care activities by a person or entity, including the Contractor that is formally designated as primarily responsible for coordinating services furnished by providers involved in the Enrollee's care, to facilitate the appropriate delivery of health care services. Care coordination activities may include but aren't limited to the coordination of specialty referrals, assistance with Ancillary Services, and referrals to and coordination with community services. **Care coordination outreach activities may include but are not limited to telephonic outreach, face-to-face visits, text, email, or mail messaging.** Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of the Enrollee's care.	This revision is necessary to provide additional clarification to the definition of Care Coordination.
2	**Glossary** **[…]** **Care Management** – An overall approach to managing Enrollees' care needs and encompasses a set of activities intended to improve patient care and reduce the need for medical services by enhancing coordination of care, eliminating duplication, and helping patients and caregivers more effectively manage health conditions.	**Glossary** **[…]** **Care Management –** An overall approach to managing Enrollees' care needs **and preferences** and encompasses a set of activities intended to improve patient care and reduce the need for medical services by enhancing coordination of care, eliminating duplication, and helping patients and caregivers more effectively manage health conditions. **Care**	This revision is necessary to provide additional clarification to the definition of Care Management.

		Management includes but is not limited to Care Coordination, Case Management, and Utilization Management.	
3	**Glossary** **[…]** **Case Management** – A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual Enrollee's health-related needs through communication and available resources to promote quality and cost-effective outcomes. Case management implicitly enhances care coordination through the designation of a case manager whose specific responsibility is to oversee and coordinate access and care delivery targeted to high-risk patients with diverse combinations of health, functional, and social needs.	**Glossary** **[…]** **Case Management –** A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual Enrollee's health-related needs **with respect to their preferences** through communication and available resources to promote quality and cost-effective outcomes. Case management implicitly enhances care coordination through the designation of a case manager whose specific responsibility is to oversee and coordinate access and care delivery targeted to high-risk patients with diverse combinations of health, functional, and social needs.	This revision is necessary to provide additional clarification to the definition of Case Management.
4	**Glossary** **[…]** **Case Manager** – A licensed registered nurse, licensed mental health practitioner, or other trained individual who is employed or contracted by the Contractor or an Enrollee's PCP. The case manager is accountable for providing intensive monitoring, follow-up, clinical management of high risk Enrollees, and care coordination activities, which include development of the Plan of Care, ensuring appropriate referrals and Timely two-way transmission of useful Enrollee information; obtaining reliable and Timely information about services other than those provided by the PCP; supporting the Enrollee in addressing social determinants of health; and supporting safe transitions in care for Enrollees moving between institutional and community care settings. The case manager may serve on one or more multi-disciplinary care	**Glossary** **[…]** **Case Manager –** A licensed registered nurse, licensed mental health practitioner, or other trained individual who is employed or contracted by the Contractor or an Enrollee's **provider**. The case manager is accountable for providing intensive monitoring, follow-up, clinical management of high risk Enrollees, and care coordination activities, which include development of the Plan of Care, ensuring appropriate referrals and Timely two-way transmission of useful Enrollee information; obtaining reliable and Timely information about services other than those provided by the PCP; supporting the Enrollee in addressing social determinants of health; and supporting safe transitions in care for Enrollees moving between institutional and community care settings. The case manager may serve on one or more multi-disciplinary care teams and is responsible	This revision is necessary to provide additional clarification to the definition of Case Manager.

	teams and is responsible for coordinating and facilitating meetings and other activities of those care teams.	for coordinating and facilitating meetings and other activities of those care teams.	
5	**Glossary** **[…]** **Documented Attempt** – A bona fide, or good faith, attempt, in writing, by the Contractor to enter into a contract with a provider, made on or after the date the Contractor signs the Contract with LDH, and no sooner than sixty (60) Calendar Days following any preceding attempt. Such attempts shall include written correspondence via certified mail that outlines contract negotiations between the parties, including rate and contract terms disclosure. If, within thirty (30) Calendar Days following the receipt date, the potential provider rejects the request or fails to respond either verbally or in writing, the Contractor may consider the request for inclusion in the provider network as denied by the provider. Provider responses are not limited to approval or rejection of the offer. This shall constitute one (1) attempt.	**Glossary** **[…]** ~~**Documented Attempt** – A bona fide, or good faith, attempt, in writing, by the Contractor to enter into a contract with a provider, made on or after the date the Contractor signs the Contract with LDH, and no sooner than sixty (60) Calendar Days following any preceding attempt. Such attempts shall include written correspondence via certified mail that outlines contract negotiations between the parties, including rate and contract terms disclosure. If, within thirty (30) Calendar Days following the receipt date, the potential provider rejects the request or fails to respond either verbally or in writing, the Contractor may consider the request for inclusion in the provider network as denied by the provider. Provider responses are not limited to approval or rejection of the offer. This shall constitute one (1) attempt.~~	This revision is necessary since this language was removed as a contract requirement.
6	**Glossary** **[…]** **Enrollees with Special Health Care Needs (SHCN)** – Individuals of any age with a behavioral health disability, physical disability, developmental disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized care approaches. Enrollees with Special Health Care Needs shall include any Enrollees who: • have complex needs such as multiple chronic conditions, co-morbidities, and co-existing functional impairments; • are at high risk for admission/readmission to a hospital within the next six (6) months; • are at high risk of institutionalization;	**Glossary** **[…]** **Enrollees with Special Health Care Needs (SHCN)** – **Special Health Care Needs Populations are individuals, across the lifespan, who have chronic physical, developmental, behavioral, or emotional conditions that significantly impact their health and daily functioning. These individuals require health and related services of a type or amount beyond what is typically needed by most people.** **They often experience:** • **Complex care needs involving multiple providers, agencies, or systems.**	This revision is necessary to provide additional clarification to the definition of Enrollees with Special Health Care Needs (SHCN).

	• have been diagnosed with a Serious Emotional Disturbance, a Severe and Persistent Mental Illness, or a Substance Use Disorder, or otherwise have significant behavioral health needs, including those Enrollees presenting to the hospital or emergency department with a suicide attempt or non-fatal opioid, stimulants, and sedative/hypnotic drug overdose reason; • are homeless as defined in Section 330(h)(5)(A) of the Public Health Service Act and codified by the US Department of Health and Human Services in 42 U.S.C. §254(b); • are women with high-risk pregnancies (i.e., pregnancies that have one or more risk factors) or who have had an adverse pregnancy outcome during the pregnancy, including preterm birth of less than thirty-seven (37) weeks; • have been recently incarcerated and are transitioning out of custody; • are at high risk of inpatient admission or emergency department visits, including certain Enrollees transitioning care across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting; • are members of the DOJ Agreement Target Population; • are enrolled under the Act 421 Children's Medicaid Option; or • receive care from other State agency programs, including, but not limited to, programs through OJJ, DCFS, or OPH.	• **Fragmented or poorly integrated care, leading to gaps in treatment and coordination.** • **Frequent transitions between care settings (e.g., hospital to home, pediatric to adult care), which can disrupt continuity and quality of care.** • **Cognitive, behavioral, social, or functional limitations that hinder self-management and independence.** • **Limited or absent support from family caregivers, increasing reliance on formal systems of care.** • **Barriers related to social determinants of health, such as poverty, housing instability, transportation challenges, language barriers, and limited health literacy, which impede access to and navigation of health services.** **These populations require person-centered, coordinated, and equitable care models that address both clinical and non-clinical needs, promote health equity, and support long-term well-being.** ~~Individuals of any age with a behavioral health disability, physical disability, developmental disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized care approaches. Enrollees with Special Health Care Needs shall include any Enrollees who:~~ ~~• have complex needs such as multiple chronic conditions, co-morbidities, and co-existing functional impairments;~~ ~~• are at high risk for admission/readmission to a hospital within the next six (6) months;~~ ~~• are at high risk of institutionalization;~~	

		~~• have been diagnosed with a Serious Emotional Disturbance, a Severe and Persistent Mental Illness, or a Substance Use Disorder, or otherwise have significant behavioral health needs, including those Enrollees presenting to the hospital or emergency department with a suicide attempt or non-fatal opioid, stimulants, and sedative/hypnotic drug overdose reason;~~ ~~• are homeless as defined in Section 330(h)(5)(A) of the Public Health Service Act and codified by the US Department of Health and Human Services in 42 U.S.C. §254(b);~~ ~~• are women with high-risk pregnancies (i.e., pregnancies that have one or more risk factors) or who have had an adverse pregnancy outcome during the pregnancy, including preterm birth of less than thirty-seven (37) weeks;~~ ~~• have been recently incarcerated and are transitioning out of custody;~~ ~~• are at high risk of inpatient admission or emergency department visits, including certain Enrollees transitioning care across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting;~~ ~~• are members of the DOJ Agreement Target Population;~~ ~~• are enrolled under the Act 421 Children's Medicaid Option; or~~ ~~• receive care from other State agency programs, including, but not limited to, programs through OJJ, DCFS, or OPH.~~	
7	**Glossary** **[…]** **<u>Fraud</u>** – 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.	**Glossary** **[…]** **<u>Fraud</u> –** 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	This revision is necessary to provide additional clarification to the definition of fraud.

	Fraud may include, but is not limited to, deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or Claiming payment for services which were never delivered or received.	applicable Federal or State law**, including but not limited to the Medical Assistance Programs Integrity Law, La. R.S. 46:437.1 et seq and the Federal False Claims Act 31 U.S.C 3729 et seq.** Fraud may include, but is not limited to, deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or Claiming payment for services which were never delivered or received.	
8	**Glossary** **[…]** **Intellectual Disability** – A type of developmental disability, formally known as mental retardation, characterized by significantly impaired intellectual and adaptive functioning. It is defined by an IQ score under seventy (70) in addition to deficits in two (2) or more adaptive behaviors that affect every day, general living. A diagnosis of intellectual disability alone does not constitute eligibility for Developmental Disabilities services.	**Glossary** **[…]** **Intellectual Disability** – A type of developmental disability~~, formally known as mental retardation,~~ characterized by significantly impaired intellectual and adaptive functioning. It is defined by an IQ score under seventy (70) in addition to deficits in two (2) or more adaptive behaviors that affect every day, general living. A diagnosis of intellectual disability alone does not constitute eligibility for Developmental Disabilities services.	This revision is necessary to remove outdated language to describe individuals with intellectual disabilities.
9	**Glossary** **[…]** **[add new definition]**	**Glossary** **[…]** **Opt-In Case Management Program – Enrollee must give consent and "opt in" to participate in this type of case management program.**	This addition is necessary to comply with the new contract terms around case management.
10	**2.2.2.4** Key Personnel Requirements **[…]** **2.2.2.4.4.1** The Chief Executive Officer (CEO) shall provide overall direction for this Contract, develop strategies, formulate policies, and oversee operations to ensure goals are met. The CEO shall serve exclusively in this position and may not function in an Executive Capacity for another insurance product. The CEO shall be the primary contact for LDH regarding all issues and shall coordinate with other key personnel to fulfill the requirements of	**2.2.2.4 Key Personnel Requirements** **[…]** **2.2.2.4.4.1** The Chief Executive Officer (CEO) shall provide overall direction for this Contract, develop strategies, formulate policies, and oversee operations to ensure goals are met. ~~The CEO shall serve exclusively in this position and may not function in an Executive Capacity for another insurance product.~~ The CEO shall be the primary contact for LDH regarding all issues and shall coordinate with other key personnel to	This revision is necessary to clarify the current language, but not change the requirement.

	the Contract. The CEO shall attend all CEO designated meetings in person as requested by LDH. If the CEO us unable to attend, a designee may attend with advance notification to LDH.	fulfill the requirements of the Contract. The CEO shall attend all CEO designated meetings in person as requested by LDH. If the CEO us unable to attend, a designee may attend with advance notification to LDH.	
11	**2.2.3** Material Subcontracts/Subcontractors **[…]** **2.2.3.7** Upon notifying any Material Subcontractor, or upon being notified by such Material Subcontractor, of the intention to terminate such subcontract, the Contractor shall notify LDH in writing no later than the same day as such notification, and shall otherwise support any necessary Enrollee transition or related activities as described in the Continuity of Care section and elsewhere in this Contract.	**2.2.3** Material Subcontracts/Subcontractors **[…]** **2.2.3.7** Upon notifying any Material Subcontractor, or upon being notified by such Material Subcontractor, of the intention to terminate such subcontract, the Contractor shall notify LDH in writing no later than the same **Calendar Day** ~~day~~ as such notification, and shall otherwise support any necessary Enrollee transition or related activities as described in the Continuity of Care section and elsewhere in this Contract.	This revision is necessary to clarify the current language, but not change the requirement.
12	**2.2.4** Performance Reviews **[…]** **2.2.4.4** The Contractor shall, within two (2) Business Days following each performance review meeting, prepare and submit to LDH for review and approval a list of any action items, requested follow-ups for the next meeting, and estimated timelines for delivery, in a form and format specified by LDH.	**2.2.4** Performance Reviews **[…]** **2.2.4.4** The Contractor shall, within ~~two (2)~~ **five (5)** Business Days following each performance review meeting, prepare and submit to LDH for review and approval a list of any action items, requested follow-ups for the next meeting, and estimated timelines for delivery, in a form and format specified by LDH.	This revision is necessary to provide more time for this requirement.
13	**2.2.7** Mental Health Parity **[…]** **2.2.7.1.1** The Contractor must comply with parity requirements for aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits, including prescription drugs as specified in 42 CFR §438.905. **2.2.7.1.2** All financial requirements or treatment limitations, including nonquantitative treatment limitations (NQTL), to mental health or substance	**2.2.7** Mental Health Parity **[…]** **2.2.7.1.1** ~~The Contractor must comply with parity requirements for aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits, including prescription drugs as specified in 42 CFR §438.905.~~**The Contractor shall complete and submit documentation and reporting when requested by LDH as part of the Readiness Review process or for ongoing parity compliance review.**	These revisions are necessary to update requirements related to compliance and documentation related to for mental health parity.

	use disorder benefits shall not be more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits, in accordance with 42 CFR §438.910. Financial requirements cannot accumulate separately for medical/surgical benefits and mental health/SUD benefits.	~~**2.2.7.1.2** All financial requirements or treatment limitations, including nonquantitative treatment limitations (NQTL), to mental health or substance use disorder benefits shall not be more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits, in accordance with 42 CFR §438.910. Financial requirements cannot accumulate separately for medical/surgical benefits and mental health/SUD benefits.~~	
14	**2.2.7** Mental Health Parity **[…]** **2.2.7.2.1** The Contractor shall conduct an initial parity analysis as part of its Readiness Review process and at other times as directed by LDH, based on benefit classifications for parity as defined by LDH. If an Enrollee is provided mental health or substance use disorder benefits in any classification of benefits, mental health and substance use disorder benefits must be provided to the Enrollee in every classification in which medical/surgical benefits are provided. **2.2.7.2.2** The Contractor shall cover, in addition to MCO Covered Services, any service necessary for compliance with the requirements for parity in mental health and substance use disorder benefits based on parity analysis. As directed by LDH as part of ongoing parity review, the Contractor may be required to cover or change services necessary for compliance, including type and amount, duration and scope of services and change policy or operational procedures in order to achieve and maintain compliance with parity requirements. **2.2.7.2.3** The Contractor shall ensure Enrollees receive a notice of Adverse Benefit Determination per 42 CFR §438.915(b) and other sections of this Contract which extend notice requirements beyond denials. The Contractor shall make available in hard copy upon request at no cost to the requestor and available on the Contractor's website, the criteria for medical necessity determinations for mental health and substance use disorder	**2.2.7** Mental Health Parity **[…]** **2.2.7.2.1** **Documentation and reporting may include, but is not limited to, both formal application through policy, training, guidelines and set procedure and informal practice within the operation for all mental health or substance use disorder benefits and medical/surgical benefits.** ~~The Contractor shall conduct an initial parity analysis as part of its Readiness Review process and at other times as directed by LDH, based on benefit classifications for parity as defined by LDH. If an Enrollee is provided mental health or substance use disorder benefits in any classification of benefits, mental health and substance use disorder benefits must be provided to the Enrollee in every classification in which medical/surgical benefits are provided~~. **2.2.7.2.2** **As directed by LDH as part of ongoing parity review, the Contractor may be required to cover or change services necessary for compliance, including type and amount, duration and scope of services and change policy or operational procedures in order to achieve and maintain compliance with parity requirements.** ~~The Contractor shall cover, in addition to MCO Covered Services, any service necessary for compliance with the requirements for parity in mental health and substance use disorder benefits based on parity analysis. As directed by LDH as part of ongoing parity review, the Contractor may be required to cover or change services necessary for compliance, including type and~~	These revisions are necessary to update requirements related to compliance and documentation related to for mental health parity.

	benefits to any Enrollee, Potential Enrollee, or provider per 42 CFR §438.236(c) and §438.915(a). **2.2.7.3** The Contractor shall require that all providers and all Subcontractors take such actions as are necessary to ensure compliance with mental health parity requirements. To the extent that the Contractor delegates oversight responsibilities for behavioral health services to a Material Subcontractor, the Contractor shall require that the Material Subcontractor complies with provisions of this Contract relating to mental health parity. The compliance and review shall be in conjunction with parity analysis on the medical/surgical benefit administration. The Contractor shall require mental health parity disclosure on provider Enrollment forms as mandated by LDH. **2.2.7.3.1** If at any time, the State moves to a single delivery system and any remaining benefits from Fee-for-Service (FFS) are completely provided through managed care, it shall be the responsibility of the Contractor to review mental health and substance user disorder and medical/surgical benefits and conduct the complete parity analysis to ensure the full scope of services available to all Enrollees of the Contractor complies with the requirements set forth in 42 CFR Part 438, Subpart K. The Contractor shall be required to provide documentation to the State and public.	~~amount, duration and scope of services and change policy or operational procedures in order to achieve and maintain compliance with parity requirements.~~ **2.2.7.2.3** **The Contractor shall provide LDH and its designees, which may include auditors and inspectors, with access to Contractor service locations, facilities, or installations, including any and all electronic and hardcopy records and files. Access described in this section shall be for the purpose of examining, auditing, or investigating mental health parity.** ~~The Contractor shall ensure Enrollees receive a notice of Adverse Benefit Determination per 42 CFR §438.915(b) and other sections of this Contract which extend notice requirements beyond denials. The Contractor shall make available in hard copy upon request at no cost to the requestor and available on the Contractor's website, the criteria for medical necessity determinations for mental health and substance use disorder benefits to any Enrollee, Potential Enrollee, or provider per 42 CFR §438.236(c) and §438.915(a).~~ **2.2.7.3** The Contractor shall require that ~~all providers and~~ all Subcontractors take such actions as are necessary to ensure compliance with mental health parity requirements. To the extent that the Contractor delegates oversight responsibilities for behavioral health services to a Material Subcontractor, the Contractor shall require that the Material Subcontractor complies with provisions of this Contract relating to mental health parity **and that documentation and reporting are compiled and jointly analyzed by the Contractor and Material Subcontractor**. ~~The compliance and review shall be in conjunction with parity analysis on the medical/surgical benefit administration. The Contractor shall require mental health parity disclosure on provider Enrollment forms as mandated by LDH.~~ **2.2.7.3.1** **The compliance and review shall be coordinated and integrated with parity analysis on the medical/surgical benefit**	

		administration. ~~If at any time, the State moves to a single delivery system and any remaining benefits from Fee-for-Service (FFS) are completely provided through managed care, it shall be the responsibility of the Contractor to review mental health and substance user disorder and medical/surgical benefits and conduct the complete parity analysis to ensure the full scope of services available to all Enrollees of the Contractor complies with the requirements set forth in 42 CFR Part 438, Subpart K. The Contractor shall be required to provide documentation to the State and public~~.	
15	**2.2.7** Mental Health Parity **[…]** **2.2.7.4** The Contractor shall provide LDH and its designees, which may include auditors and inspectors, with access to Contractor service locations, facilities, or installations, including any and all electronic and hardcopy records and files. Access described in this section shall be for the purpose of examining, auditing, or investigating mental health parity.	**2.2.7** Mental Health Parity **[…]** ~~**2.2.7.4** The Contractor shall provide LDH and its designees, which may include auditors and inspectors, with access to Contractor service locations, facilities, or installations, including any and all electronic and hardcopy records and files. Access described in this section shall be for the purpose of examining, auditing, or investigating mental health parity.~~	This revision is necessary to update requirements related to compliance and documentation related to mental health parity.
16	**2.3** Eligibility and Enrollment **[…]** **2.3.5** Mandatory MCO Populations for All MCO Covered Services Except SBHS and CSoC Services The Contractor shall accept Enrollment of children who are functionally eligible and participate in the CSoC program for all services as specified in the Services section, except SBHS and CSoC services. For this population, Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (TGH), and SUD Residential services (ASAM Levels 3.1, 3.2-wm, 3.5 and 3.7) remain the responsibility of the Contractor. The Contractor shall implement procedures to coordinate services it provides to the Enrollee with the services the Enrollee receives from the CSoC contractor, including sharing the results	**2.3** Eligibility and Enrollment **[…]** **2.3.5** Mandatory MCO Populations for All MCO Covered Services Except SBHS and CSoC Services The Contractor shall accept Enrollment of children who are functionally eligible and participate in the CSoC program for all services as specified in the Services section, except SBHS and CSoC services. For this population, Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (TGH), and SUD Residential services ~~(ASAM Levels 3.1, 3.2-wm, 3.5 and 3.7)~~ remain the responsibility of the Contractor. The Contractor shall implement procedures to coordinate	These revisions are necessary to comply conversion of substance use service standards to the American Society of Addiction Medicine (ASAM) 4th Edition standards. This change is necessary to align contractual obligations with recent budget approval received to support statewide implementation of the updated ASAM criteria, effective January 1, 2026.

	of any identification and assessment of that Enrollee's needs to prevent duplication of those activities as required by 42 CFR §438.208(b)(4).	services it provides to the Enrollee with the services the Enrollee receives from the CSoC contractor, including sharing the results of any identification and assessment of that Enrollee's needs to prevent duplication of those activities as required by 42 CFR §438.208(b)(4).	
17	**2.3.10** Assistance with Medicaid Eligibility Renewal **[…]** **[new provision]**	**2.3.10** Assistance with Medicaid Eligibility Renewal **[…]** **2.3.10.1 The Contractor may reach out to former Enrollees of their managed care plan, who have been disenrolled by the State due to the loss of Medicaid eligibility, up to sixty (60) calendar days post disenrollment, to assist them in enrolling in health coverage, provided it does not violate applicable marketing rules prohibiting discrimination.**	This addition is necessary to give the MCOs more flexibility in outreaching to prior enrollees.
18	**2.3.12.4** Newborn Enrollment **[…]** **2.3.12.4.3.1** Disenroll the newborn from the MCO in which the newborn was incorrectly enrolled effective the last day of the month of discovery, unless an MCO choice separate from the mother's MCO is on record; **2.3.12.4.3.2** Enroll the newborn in the correct MCO effective the first day of the month following discovery, unless a MCO choice separate from the mother's MCO is on record;	**2.3.12.4** Newborn Enrollment **[…]** **2.3.12.4.3.1** Disenroll the newborn from the MCO in which the newborn was incorrectly enrolled effective the last **Calendar Day** ~~day~~ of the **month of discovery**, unless an MCO choice separate from the mother's MCO is on record; **2.3.12.4.3.2** Enroll the newborn in the correct MCO effective the first **Calendar Day** ~~day~~ of the month following discovery, unless a MCO choice separate from the mother's MCO is on record;	This revision is necessary to clarify the current language, but not change the requirement.
19	**2.3.13.4** Disenrollment Effective Date **[…]** **2.3.13.4.1** The effective date of Disenrollment shall be no later than the first (1st) day of the second (2nd) month following the calendar month in which the request for Disenrollment is filed. **2.3.13.4.2** If LDH or its designee fails to make a Disenrollment	**2.3.13.4** Disenrollment Effective Date **[…]** **2.3.13.4.1** The effective date of Disenrollment shall be no later than the first (1st) **Calendar Day** ~~day~~ of the second (2nd) month following the calendar month in which the request for Disenrollment is filed. **2.3.13.4.2** If LDH or its designee fails to make a Disenrollment	This revision is necessary to clarify the current language, but not change the requirement.

	determination by the first (1st) day of the second (2nd) month following the month in which the request for Disenrollment is filed, the Disenrollment is deemed approved.	determination by the first (1st) **Calendar Day** ~~day~~ of the second (2nd) month following the month in which the request for Disenrollment is filed, the Disenrollment is deemed approved.	
20	**2.4.5** Value-Added Benefits **[…]** **2.4.5.4** The Contractor may propose to add to or expand upon the VAB(s) proposed in the Contractor's RFP response as pre-approved in writing by LDH. Deletions or reductions to the VAB(s) may be proposed on an annual basis and shall be submitted to LDH for approval no later than six (6) months in advance of the Enrollment period. The Contractor shall submit requests in accordance with the **MCO Manual**.	**2.4.5** Value-Added Benefits **[…]** **2.4.5.4** The Contractor may propose to add to or expand upon the VAB(s) proposed in the Contractor's RFP response as pre-approved in writing by LDH. Deletions or reductions to the VAB(s) may be proposed on an annual basis and shall be submitted to LDH for approval ~~no later than six (6) months in advance of the Enrollment period~~ **by October 1 of each calendar year to be effective January 1 of the following year. The Contractor may also propose adding new VABs on a quarterly basis**. The Contractor shall submit requests in accordance with the **MCO Manual**.	This revision is necessary to align with the change to the open enrollment period.
21	**2.5 Population Health and Social Determinants of Health** The Contractor shall participate in and support LDH's efforts to advance population health. **[…]** **2.5.1.2.8** Tobacco cessation; and **2.5.1.2.9** Early childhood health and development, including Adverse Childhood Experiences (ACEs);	**2.5 Population Health and Social Determinants of Health** The Contractor shall participate in and support LDH's efforts to advance population health. **[…]** **2.5.1.2.8** Tobacco cessation; ~~and~~ **2.5.1.2.9** Early childhood health and development, including Adverse Childhood Experiences (ACEs); **2.5.1.2.10 Obesity management;** **2.5.1.2.11 Asthma;** **2.5.1.2.12 COPD;** **2.5.1.2.13 Sickle Cell Disease; and** **2.5.1.2.14 Cancer, to include, but not limited to Breast Cancer, Cervical Cancer, Colorectal Cancer, Lung Cancer and Other Cancer Types.**	This revision is necessary to add additional populations to this requirement.

22	**2.5** Population Health and Social Determinants of Health The Contractor shall participate in and support LDH's efforts to advance population health. **[…]** **2.5.1.8** Referral to OCDD Waiver services, EarlySteps and services under the Office of Behavioral Health; **2.5.1.9** Description of how the care management program will serve to advance population health goals; and	**2.5** Population Health and Social Determinants of Health The Contractor shall participate in and support LDH's efforts to advance population health. **[…]** **2.5.1.8** Referral to OCDD Waiver services~~,~~ **and** EarlySteps ~~and services under the Office of Behavioral Health~~; **2.5.1.9 Referral to services under the Office of Behavioral Health;** **2.5.1.10** Description of how the care management program will serve to advance population health goals; and **[subsequent items will be renumbered]**	This revision is necessary to clarify the current language, but not change the requirement.
23	**2.6.4** MCO Performance Withhold Linked to Health Equity LDH may designate certain health equity related tasks and/or benchmarks to be linked to a portion of the MCO performance withhold consistent with the withhold requirements in Part 4 of the Contract.	~~**2.6.4 MCO Performance Withhold Linked to Health Equity**~~ ~~LDH may designate certain health equity related tasks and/or benchmarks to be linked to a portion of the MCO performance withhold consistent with the withhold requirements in Part 4 of the Contract.~~	This revision is necessary to remove the withhold language for health equity. The department is moving to only incentivizing meeting quality metrics.
24	**2.7 Care Management** **2.7.1** Comprehensive Care Management Program The Contractor shall offer a comprehensive care management program to support Enrollees, regardless of age, based on an individualized assessment of care needs. At a minimum, care management shall include both the populations and functions described below. **2.7.2** Health Needs Assessment **2.7.2.1** The Contractor shall attempt to conduct Enrollee Health Needs Assessments (HNA) as part of the Enrollee welcome call to identify health and functional needs of Enrollees, and to identify Enrollees who require short-	**2.7 ~~Care~~ Case Management** **2.7.1** Comprehensive ~~Care~~ **Case** Management Program The Contractor shall offer a comprehensive ~~care~~ **case** management program to support Enrollees, regardless of age, based on **qualifying criteria and/or** an individualized assessment of care needs. At a minimum, ~~care~~ **case** management shall include both the populations and functions described below. **When appropriate, the state contract shall supersede NCQA requirements related to the provision of case management services to enrollees.** ~~**2.7.2 Health Needs Assessment**~~	This revision is necessary to clarify some of the current language.

	term care coordination or Case Management for medical, behavioral or social needs. When an Enrollee is a child, the HNA shall be completed by the Enrollee's parent or legal guardian. **2.7.2.2** The Contractor shall develop, implement, and maintain procedures for completing an initial HNA for each Enrollee, and shall make best efforts to complete such screening within ninety (90) Calendar Days of the Enrollee's effective date of Enrollment [42 CFR §438.208(b)]. If the initial HNA attempt is unsuccessful, the Contractor shall attempt to conduct, and document its efforts to conduct, the HNA on at least three (3) different occasions, at different times of the day and on different days of the week. **2.7.2.3** The Contractor shall provide HNA data to the Enrollee's assigned PCP, and to LDH as requested. **2.7.2.4** The Contractor's HNA shall: **2.7.2.4.1** Utilize a common survey-based instrument, which shall be developed by LDH as described in Part 3: State Responsibilities; **2.7.2.4.2** Be made available to Enrollees in multiple formats including web-based, print, and telephone; **2.7.2.4.3** Be conducted with the consent of the Enrollee; **2.7.2.4.4** Identify individuals for referral to Case Management; **2.7.2.4.5** Screen for needs relevant to priority social determinants of health as described in the Population Health and Social Determinants of Health section; and **2.7.2.4.6** Include disclosures of how information will be used.	~~**2.7.2.1** The Contractor shall attempt to conduct Enrollee Health Needs Assessments (HNA) as part of the Enrollee welcome call to identify health and functional needs of Enrollees, and to identify Enrollees who require short-term care coordination or Case Management for medical, behavioral or social needs. When an Enrollee is a child, the HNA shall be completed by the Enrollee's parent or legal guardian.~~ ~~**2.7.2.2** The Contractor shall develop, implement, and maintain procedures for completing an initial HNA for each Enrollee, and shall make best efforts to complete such screening within ninety (90) Calendar Days of the Enrollee's effective date of Enrollment [42 CFR §438.208(b)]. If the initial HNA attempt is unsuccessful, the Contractor shall attempt to conduct, and document its efforts to conduct, the HNA on at least three (3) different occasions, at different times of the day and on different days of the week.~~ ~~**2.7.2.3** The Contractor shall provide HNA data to the Enrollee's assigned PCP, and to LDH as requested.~~ ~~**2.7.2.4** The Contractor's HNA shall:~~ ~~**2.7.2.4.1** Utilize a common survey-based instrument, which shall be developed by LDH as described in Part 3: State Responsibilities;~~ ~~**2.7.2.4.2** Be made available to Enrollees in multiple formats including web-based, print, and telephone;~~ ~~**2.7.2.4.3** Be conducted with the consent of the Enrollee;~~ ~~**2.7.2.4.4** Identify individuals for referral to Case Management;~~ ~~**2.7.2.4.5** Screen for needs relevant to priority social determinants of health as described in the Population Health and Social Determinants of Health section; and~~ ~~**2.7.2.4.6** Include disclosures of how information will be used.~~	

		[subsequent items will be renumbered]	
25	**2.7.3** Case Management Assessment **[…]** **2.7.3.2** The Contractor shall implement mechanisms to provide other Enrollees referred to Case Management with a Case Management assessment to identify any needs or conditions of the Enrollee that require intervention by the MCO, a course of treatment, or regular care monitoring. **2.7.3.3** The Contractor shall complete the required assessment for at least ninety percent (90%) of those Enrollees that the Contractor is able to contact and are willing to engage within ninety (90) Calendar Days of being identified as having SHCN or of being referred to Case Management. **2.7.3.4** The Contractor shall offer Case Management to all Enrollees with SHCN regardless of information gathered through this comprehensive assessment or the HNA.	~~**2.7.3**~~ **2.7.2** Case Management Assessment **[…]** ~~**2.7.3.2**~~ **2.7.2.2** The Contractor shall implement mechanisms to provide other Enrollees referred to Case Management with a **comprehensive** Case Management assessment to identify any needs or conditions of the Enrollee that require intervention by the ~~MCO~~ **Contractor**, a course of treatment, or regular care monitoring. **2.7.2.3 The Contractor shall use a common comprehensive case management assessment tool approved by LDH.** **2.7.2.4 The comprehensive case management assessment shall supersede the Health Needs Assessment (HNA), for members who are enrolled in Case Management and do not have an HNA on file.** ~~**2.7.3.3**~~ **2.7.2.5** The Contractor shall complete the required **case management** assessment for at least ninety percent (90%) of those Enrollees that the Contractor is able to contact and are willing to engage within ~~ninety~~ **sixty** (~~9~~60) Calendar Days of being identified as having SHCN or of being referred to Case Management. ~~**2.7.3.4**~~ **2.7.2.6** The Contractor shall ~~offer~~ **attempt to contact** ~~Case Management~~ all Enrollees with SHCN **to engage them in the Case Management program.** ~~regardless of information gathered through this comprehensive assessment or the HNA.~~ **The MCO may use any combination of telephonic, in-person, virtual, digital (including text and email), or traditional mail options based on the individuals' needs and preferences to outreach and engage in all case management-related activities to include but not be limited to completion of the**	This revision is necessary to clarify some of the current language.

		comprehensive assessment/reassessment, plan of care development/updates, follow up, and multidisciplinary team meetings. **[subsequent items will be renumbered]**	
26	**2.7.5** Tiered Case Management Based on Need The Contractor shall implement a tiered Case Management program that provides for differing levels of Case Management based on an individual Enrollee's needs. The Contractor shall engage Enrollees, or their parent or legal guardian, as appropriate, in a level of Case Management commensurate with their risk score as identified through predictive modeling, if applicable, combined with the care needs identified in the Enrollee's Plan of Care (POC) and HNA, as described below. If requested by the Enrollee, or the Enrollee's parent or legal guardian, the frequency and/or method of engagement may be increased, reduced, or substituted or declined. The Contractor shall retain documentation of such requests. Where the Enrollee's PCP or behavioral health provider offers Case Management, the Contractor shall support the provider as the lead case manager on the multi-disciplinary care team. The Contractor shall maintain three (3) levels of Case Management and Transitional Case Management for individuals as they move between care settings.	~~**2.7.5**~~ **2.7.4** ~~Tiered~~ Case Management Based on Need The Contractor shall implement a ~~tiered~~ Case Management program that provides for differing levels of Case Management based on an individual Enrollee's needs **with respect to their preferences**. The Contractor shall engage Enrollees, or their parent or legal guardian, as appropriate, in a level of Case Management commensurate with their ~~risk score as identified through predictive modeling, if applicable, combined with the~~ care needs identified ~~in the Enrollee's Plan of Care (POC) and HNA~~ **through SHCN designation or results from the Health Needs Assessment**, as described below. If requested by the Enrollee, or the Enrollee's parent or legal guardian, the frequency and/or method of engagement may be increased, reduced, or substituted or declined. The Contractor shall retain documentation of such requests. Where the Enrollee's PCP or behavioral health provider offers Case Management, the Contractor shall support the provider as the lead case manager on the multi-disciplinary care team. The Contractor shall maintain ~~three (3)~~ **two (2)** levels of Case Management and Transitional Case Management for individuals as they move between care settings.	This revision is necessary to clarify some of the current language.
27	**2.7.5.1** Intensive Case Management for High Risk Enrollees (High) (Tier 3) Enrollees engaged in intensive Case Management are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within thirty (30) Calendar	~~**2.7.5.1** Intensive Case Management for High Risk Enrollees (High) (Tier 3)~~ ~~Enrollees engaged in intensive Case Management are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within~~	This revision is necessary to clarify some of the current language.

	Days of the Case Management assessment being completed and shall include assessment of the home environment and priority SDOH (see Population Health and Social Determinants of Health section). Case Management meetings shall occur at least monthly, in person, in the Enrollee's preferred setting, or more as required within the Enrollee's POC, or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i), with monthly updates to the POC and formal in person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of monthly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 3 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs. **2.7.5.2** Case Management (Medium) (Tier 2) Enrollees engaged in the medium level of Case Management are typically of rising risk and need focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within thirty (30) Calendar Days of Case Management assessment being completed and include assessment of the home environment and priority SDOH (see Population Health and Social Determinants of Health section). Case Management meetings shall occur at least monthly, with quarterly updates to the POC, or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i), and formal in-person re-assessment quarterly. Case Management may integrate community health worker support. Attestations	~~thirty (30) Calendar Days of the Case Management assessment being completed and shall include assessment of the home environment and priority SDOH (see Population Health and Social Determinants of Health section). Case Management meetings shall occur at least monthly, in person, in the Enrollee's preferred setting, or more as required within the Enrollee's POC, or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i), with monthly updates to the POC and formal in person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of monthly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 3 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs.~~ ~~**2.7.5.2** Case Management (Medium) (Tier 2)~~ ~~Enrollees engaged in the medium level of Case Management are typically of rising risk and need focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within thirty (30) Calendar Days of Case Management assessment being completed and include assessment of the home environment and priority SDOH (see Population Health and Social Determinants of Health section). Case Management meetings shall occur at least monthly, with quarterly updates to the POC, or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i), and formal in-person re-~~	

	of quarterly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 2 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs.	~~assessment quarterly. Case Management may integrate community health worker support. Attestations of quarterly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 2 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs.~~ **2.7.4.1** Case Management **Program** for High-Risk Enrollees ~~(High) (Tier 3)~~ ~~Enrollees engaged in the medium level of Case Management are typically of rising risk and need focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within thirty (30) Calendar Days of Case Management assessment being completed and include assessment of the home environment and priority SDOH (see Population Health and Social Determinants of Health section). Case Management meetings shall occur at least monthly, with quarterly updates to the POC, or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i), and formal in-person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of quarterly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 2 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs.~~	

		Enrollees with SHCN enrolled in the case management program or those identified as high-risk for the case management program are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH. **2.7.4.1.1 The Contractor shall attempt to outreach, and document its efforts to outreach to engage the Enrollees on at least three (3) different occasions, at different times of the day, and on different days of the week within thirty (30) days of being identified for case management services.** **2.7.4.1.2 Enrollees will be outreached for engagement in case management and will be offered opportunity to complete a comprehensive Case Management assessment which shall be initiated within 30 days and completed within sixty (60) days of being identified for case management services.** **2.7.4.1.3 A POC shall be completed within thirty (30) Calendar Days of the Case Management assessment being completed and shall include additional assessment of the home environment, as appropriate, and priority SDOH needs (see *Population Health and Social Determinants of Health* section).** **2.7.4.1.4 The POC shall be made available to the Enrollee's PCP electronically or in other formats as needed or requested.** **2.7.4.1.5 Case Management contact will occur at a minimum monthly, but may occur more as needed. Less frequent contact is allowed when based on Enrollee preferences.** **2.7.4.1.6 Case Management multi-disciplinary team meetings shall occur at least monthly quarterly or as indicated based on Enrollee preferences within the Enrollee's POC, or as needed to coordinate the**	

		services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i). **2.7.4.1.7 POC updates will occur at a minimum of every thirty (30) days with successful member outreach.** **2.7.4.1.8 Formal re-assessment will occur at a minimum of every ninety (90) days.** **2.7.4.1.9 Case Management may integrate community health worker support.** **2.7.4.1.10 Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs.**	
28	**2.7.5.3** Case Management (Low) (Tier 1) Enrollees engaged in this level of Case Management are of the lowest level of risk within the Case Management program and typically require support in care coordination and in addressing SDOH. A POC shall be completed in person within ninety (90) Calendar Days of the Case Management assessment being completed and include assessment of the home environment and priority SDOH (see Population Health and Social Determinants of Health section). Case Management meetings shall occur at least quarterly, or more as required within the Enrollee's POC, or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i), with annual updates to the POC and formal in-person re-assessment annually. Attestations of annual updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed.	**2.7.4.2** Case Management **for Rising Risk/ Low Risk** ~~(Low) (Tier 1)~~ ~~Enrollees engaged in this level of Case Management are of the lowest level of risk within the Case Management program and typically require support in care coordination and in addressing SDOH. A POC shall be completed in person within ninety (90) Calendar Days of the Case Management assessment being completed and include assessment of the home environment and priority SDOH (see Population Health and Social Determinants of Health section). Case Management meetings shall occur at least quarterly, or more as required within the Enrollee's POC, or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i), with annual updates to the POC and formal in-person re-assessment annually. Attestations of annual updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed.~~	This revision is necessary to clarify some of the current language.

		Enrollees engaged in this program of Case Management typically require support in care coordination and in addressing SDOH. **2.7.4.2.1 A Comprehensive Case Management assessment shall be initiated within 30 days and completed within sixty (60) days of being identified for case management services. The Contractor shall attempt to outreach, and document its efforts to outreach to engage the Enrollees on at least three (3) different occasions, at different times of the day, and on different days of the week within thirty (30) days of the initial outreach attempt.** **2.7.4.2.2 A POC shall be completed within sixty (60) Calendar Days of the Comprehensive Case Management assessment being completed and shall include additional assessment of the home environment, as appropriate, and priority SDOH needs (see Population Health and Social Determinants of Health section).** **2.7.4.2.3 The POC shall be made available to the Enrollee's PCP electronically as needed or requested.** **2.7.4.2.4 Case Management contact will occur at a minimum of quarterly or as needed based on Enrollee preferences.** **2.7.4.2.5 Case Management multi-disciplinary meetings shall occur as needed to coordinate the services identified in the POC with the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i).** **2.7.4.2.6 POC updates will occur quarterly.**	

29	**2.7.5.4** Transitional Case Management The Contractor shall implement procedures to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i). The Contractor shall provide Transitional Case Management for Enrollees not already enrolled in Case Management Tiers 1, 2, or 3 to support transitions between institutional and community care settings, including, but not limited to, transitions to/from inpatient hospitals, nursing facilities (not including members of the DOJ Agreement Target Population), psychiatric residential treatment facilities (PRTFs), therapeutic group homes (TGHs), ICF/IIDs, residential substance use disorder treatment settings, and incarceration and transitions to permanent supportive housing. Transitional Case Management shall include: **2.7.5.4.1** Development of a transition POC in coordination with the care setting, the Enrollee, and other key members of an Enrollee's multi-disciplinary team prior to the transition which is provided in writing to the Enrollee upon discharge, includes post discharge care appointments and linkages as appropriate, medication reconciliation, patient education and self-management strategies, and addresses Prior Authorization needs. The Enrollee shall be provided the case manager's name and contact information prior to discharge. **2.7.5.4.2** For Enrollees preparing for discharge from a PRTF, TGH, or ICF/IID, aftercare services shall be in place thirty (30) Calendar Days prior to discharge. **2.7.5.4.3** Ensuring that the setting from which the Enrollee is transitioning is sharing information with the Enrollee's PCP and behavioral health providers regarding the treatment received and contact information. **2.7.5.4.4** Follow up with Enrollees within seven (7) Calendar Days	**2.7.4.3** Transitional Case Management The Contractor shall implement procedures ~~to~~ **that allow for** ~~coordinate the~~ **collaboration with providers and the coordination of** services ~~that it furnishes to the~~ **for** Enrollees **transitioning** between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i). The Contractor shall provide Transitional Case Management for Enrollees**,** not ~~already~~ enrolled in Case Management, ~~Tiers 1, 2, or 3 to ,~~ **with the following high-risk diagnoses:** • **Sepsis** • **Stroke** • **Congestive Heart Failure** • **Coronary Artery Disease** • **Cardiac Arrhythmias** • **Chronic Obstructive Pulmonary Disease** • **Diabetes Mellitus** • **Spinal Stenosis** • **Hip Fracture** • **Peripheral Vascular Disease** • **Deep Vein Thrombosis** • **Pulmonary Embolism** • **Schizophrenia** • **Suicide/Self-harm** • **Overdose** • **Major Depressive Disorder** • **Schizoaffective Disorder** • **Bi-Polar Disorder** • **Substance Use Dependence Disorder** • **And other behavioral health diagnoses in which a person may need assistance transitioning from one level of care to another.** **Transitional Case Management** supports transitions between	This revision is necessary to clarify some of the current language.

	following discharge/transition to ensure that services are being provided as detailed within the Enrollee's transition POC. The POC shall identify circumstances in which the follow-up includes a face-to-face visit. **2.7.5.4.5** Additional follow-up as detailed in the discharge plan. **2.7.5.4.6** Coordination across the multi-disciplinary team involved in Transitional Case Management for Enrollees. **2.7.5.4.7** For Enrollees identified as homeless at the time of care transition, the care management team shall include a housing specialist, as described in the Individual Plan of Care subsection, on the multi-disciplinary care team. Housing specialists shall also be used to ensure Enrollees transitioning from facility to community are connected to appropriate housing resources, including, but not limited to, referral of Potential Enrollees to Contractor's Permanent Supportive Housing liaison for application to the Louisiana Permanent Supportive Housing program. **2.7.6** Case Management for Individuals in DOJ Agreement Target Population (Case 3:18-cv-00608, Middle District of Louisiana) The Contractor shall develop a specialized community Case Management program consistent with the DOJ Agreement and LDH-issued guidance for the target population transitioning or diverted from nursing facility level of care using subcontracted community case managers who meet the qualifications established by LDH. The Contractor shall make a referral to a community Case Management agency within one (1) Business Day of receipt of a referral from LDH. The Contractor shall maintain ultimate responsibility for ensuring the Case Management needs of the target population are met by community case managers and community case managers satisfactorily completing required activities. **2.7.8** Individual Plan of Care **2.7.8.1** The Contractor shall develop a comprehensive individualized, person-centered POC for all Enrollees who are found eligible for Case Management. When an Enrollee receives services from the Contractor only	institutional and community care settings, including, but not limited to, transitions to/from inpatient hospitals, nursing facilities (not including members of the DOJ Agreement Target Population)~~,~~. **Transitional Case Management shall be available for** psychiatric residential treatment facilities (PRTFs), therapeutic group homes (TGHs), ICF/IIDs, residential substance use disorder treatment settings, and incarceration and transitions to permanent supportive housing **upon notification to the MCO.** Transitional Case Management shall include: **2.7.4.3.1** ~~Development of a transition POC in coordination with the care setting, the Enrollee, and other key members of an Enrollee's multi-disciplinary team prior to the transition which is provided in writing to the Enrollee upon discharge, includes post discharge care appointments and linkages as appropriate, medication reconciliation, patient education and self-management strategies, and addresses Prior Authorization needs. The Enrollee shall be provided the case manager's name and contact information prior to discharge.~~ **The Contractor shall support with transition between settings of care based on the member needs upon receipt of notification from the facility. This includes supporting facility discharge planning through activities such as arranging post discharge appointments and linkages as appropriate, medication reconciliation review, patient education and self-management strategies, coordinating with provider facility's treatment team, Utilization Management and arranging post discharge appointments.** **2.7.4.3.2** For Enrollees preparing for discharge from a PRTF, TGH, or ICF/IID, **upon receipt of notification from the facility, the Contractor will support facilities in developing a discharge plan that includes** aftercare services**; which** ~~shall be in place thirty (30) Calendar Days prior to discharge.~~ **the Contractor shall proactively coordinate with the provider facility's treatment team and the guardian to discuss ongoing treatment needs, including specialized services that may not be**	

	for SBHS, the POC shall focus on coordination and integration, as appropriate. When an Enrollee receives services requiring a POC from LDH, such as Home and Community Based Waiver services or services through OPH, the Contractor shall collaborate with LDH or its designee in developing the POC. **2.7.8.2** Development of the POC shall be a person-centered process led by the Enrollee and their case manager with significant input from members of the Enrollee's interdisciplinary care team. When an Enrollee receives SBHS and has treatment plans developed through their behavioral health providers, the Contractor shall work with the Enrollee's behavioral health providers in order to incorporate the treatment plans into the Enrollee's overall POC and to support the Enrollee and the provider in their efforts to implement the treatment plan. **2.7.8.3** The POC shall be based on the principles of self-determination and recovery, and shall include all medically necessary services identified by the Enrollee's providers as well as the care coordination and other supports to be provided by the Contractor. **2.7.8.4** The POC shall be reviewed and revised upon reassessment of functional need. The POC revisions shall occur at least at the frequency required in the Tiered Case Management Based on Need section, or when the Enrollee's circumstances or needs change significantly, or at the request of the Enrollee, their parent or legal guardian, or a member of the multi-disciplinary care team. **2.7.9** Multi-Disciplinary Care Team **2.7.9.1** The Contractor shall identify a multi-disciplinary care team to serve each Enrollee based on individual need for all Enrollees in Case Management Tiers 2 and 3 and Transitional Case Management. The Contractor shall assign lead case managers based on an Enrollee's priority care needs, as identified through the POC. Where behavioral health is an Enrollee's primary health issue, the case manager shall be a behavioral health case manager. As needed, case managers with expertise in physical or behavioral health care	**routinely available in standard step-down settings, a minimum of sixty (60) calendar days prior to anticipated discharge. The Contractor shall ensure that all needed outpatient behavioral health services have been identified and scheduled for the youth thirty (30) calendar days prior to anticipated discharge. If the recommended services will not be available to the member at the time of discharge, then the Contractor shall recommend, identify, and schedule alternative services that will meet the member's needs.** **2.7.4.3.3** ~~Ensuring that the setting from which the Enrollee is transitioning is sharing information with the Enrollee's PCP and behavioral health providers regarding the treatment received and contact information.~~ **Follow up with Enrollees within seven (7) Calendar Days following discharge/transition notification date to ensure that services are being provided or scheduled as detailed within the Enrollee's Discharge Plan.** **2.7.4.3.4** ~~Follow up with Enrollees within seven (7) Calendar Days following discharge/transition to ensure that services are being provided as detailed within the Enrollee's transition POC. The POC shall identify circumstances in which the follow-up includes a face-to-face visit.~~ **For Enrollees identified as homeless at the time of care transition, the care management team shall include a housing specialist on the multi-disciplinary care team. Housing specialists shall also be used to ensure Enrollees transitioning from facility to community are connected to appropriate housing resources.** ~~**2.7.5.4.2** Additional follow-up as detailed in the discharge plan.~~ ~~**2.7.5.4.3** Coordination across the multi-disciplinary team involved in Transitional Case Management for Enrollees.~~ ~~**2.7.5.4.7** For Enrollees identified as homeless at the time of care transition, the care management team shall include a housing specialist, as described in the Individual Plan of Care subsection, on the multi-~~	

	will support lead case managers where there are secondary diagnoses. If the Enrollee is under the age of six (6), the lead case manager shall have expertise in early childhood mental health or access to a consultant with expertise in infant and early childhood mental health. **2.7.9.2** Physical and behavioral health case managers shall be co-located and based in Louisiana to allow for integration of Case Management for Enrollees with both physical and behavioral health care needs. The Contractor may request exceptions in writing to this requirement for individual case managers. **2.7.9.3** In addition to the case manager and the Enrollee and their family or Authorized Representative, the care team shall include members based on an Enrollee's specific care needs and goals identified in the POC. The team may change over time as the Enrollee's care needs change. Potential team members shall include, but are not limited to: **2.7.9.3.1** Primary care provider; **2.7.9.3.2** Behavioral health providers; **2.7.9.3.3** Specialists; **2.7.9.3.4** Pharmacists; **2.7.9.3.5** Community health workers; **2.7.9.3.6** Home and community based service providers and managers; **2.7.9.3.7** Housing specialists, if the Enrollee is identified as homeless; and **2.7.9.3.8** State staff, including transition coordinators. **2.7.9.4** Teams shall meet at regular intervals as identified in the POC, based on the individual's care needs. When possible, the team shall meet in person but when necessary, team members may participate in meetings via telephone. At a minimum, multi-disciplinary care teams shall meet on a	~~disciplinary care team. Housing specialists shall also be used to ensure Enrollees transitioning from facility to community are connected to appropriate housing resources, including, but not limited to, referral of Potential Enrollees to Contractor's Permanent Supportive Housing liaison for application to the Louisiana Permanent Supportive Housing program.~~ **2.7.6** Case Management for Individuals in DOJ Agreement Target Population (Case 3:18-cv-00608, Middle District of Louisiana) The Contractor shall develop a specialized community Case Management program consistent with the DOJ Agreement and LDH-issued guidance for the target population transitioning or diverted from nursing facility level of care using subcontracted community case managers who meet the qualifications established by LDH. The Contractor shall make a referral to a community Case Management agency within one (1) Business Day of receipt of a referral from LDH. The Contractor shall maintain ultimate responsibility for ensuring the Case Management needs of the target population are met by community case managers and community case managers satisfactorily completing required activities. **In addition, the Contractor shall consider DOJ at-risk members as special health care needs population eligible for MCO case management. The Contractor shall identify members who meet the at-risk criteria and provide case management based on member needs and preferences.** **2.7.7.11 The Contractor and its Level II evaluators shall utilize technology and systems required by LDH for the transferring of information related to PASRR requests including submission of Level II evaluations and receipt of final determinations as outlined within the DOJ Compliance Guide.**	

	monthly basis for Enrollees in Tier 3 Case Management and on a quarterly basis for Enrollees in Tier 2 Case Management. **2.7.10** Case Management Policies and Procedures The Contractor shall develop, implement, and maintain criteria and protocols for determining which Case Management activities may benefit an Enrollee. The Contractor shall submit such criteria and protocols to LDH or its designee as part of Readiness Review and prior to any substantive revisions. Where the Contractor delegates Case Management to a Network Provider, the Contractor shall have a written plan in place for monitoring and oversight of performance under any such agreements, including provisions for assessing Provider compliance and corrective actions and/or termination as appropriate. The Contractor shall develop, implement, and maintain procedures for providing Case Management. Case Management procedures shall: **2.7.10.1** Be subject to approval by LDH in writing; **2.7.10.2** Include procedures for contacting Enrollees to complete the HNA and comprehensive assessment, including number of contact attempts and methods of contact; **2.7.10.3** Include procedures for acquiring and documenting Enrollees' consent (or the Enrollee's family or Authorized Representative) to receive Case Management and for the Contractor to share information about an Enrollee's care with Enrollee's providers to promote coordination and integration; **2.7.10.4** **I**nclude a plan describing how management of behavioral health services shall be integrated into the overall care management of the Enrollee population; **2.7.10.5** Include criteria and protocols for ensuring appropriate staffing ratios and caseloads for case managers and other staff involved in care management activities in line with industry practices;	**2.7.8** Individual Plan of Care **2.7.8.1** The Contractor shall develop a comprehensive individualized, person centered POC for all Enrollees who are found eligible for Case Management. When an Enrollee receives services from the Contractor only for SBHS, the POC shall focus on coordination and integration, as appropriate. When an Enrollee receives services requiring a POC from LDH, such as Home and Community Based Waiver services or services through OPH, the Contractor shall collaborate with LDH or its designee in developing the POC. **2.7.8.2** Development of the POC shall be a person-centered process led by the Enrollee and their case manager with significant input from members of the Enrollee's ~~inter~~ **multi**disciplinary care team. When an Enrollee receives SBHS and has treatment plans developed through their behavioral health providers, the Contractor shall **attempt to** work with the Enrollee's behavioral health providers in order to incorporate the treatment plans into the Enrollee's overall POC and to support the Enrollee and the provider in their efforts to implement the treatment plan. **2.7.8.3** The POC shall be based on the principles of self-determination and recovery, and shall include all medically necessary services identified by the Enrollee's providers as well as the care coordination and other supports to be provided by the Contractor. **2.7.8.4** The POC shall be reviewed and revised upon reassessment of functional need. The POC revisions shall occur at least at the frequency required in the ~~*Tiered*~~ *Case Management Based on Need* section, or when the Enrollee's circumstances or needs change significantly, or at the	

	2.7.10.6 Include processes for the Contractor to measure the effectiveness and quality of the Contractor's Case Management procedures. Such processes shall include: **2.7.10.6.1** Tracking of frequency and type of Case Management contact; **2.7.10.6.2** Developing and implementing inclusion criteria for different tiers of Case Management, including how the HNA and comprehensive assessment are utilized; **2.7.10.6.3** Determining expected outcomes in subgroups at different tiers of Case Management, including an impact analysis of Case Management on the use of the ED, inpatient admissions, and follow-up care; **2.7.10.6.4** Expected Case Management penetration and target rate of engagement; **2.7.10.6.5** Identification of relevant measurement processes or outcomes; and **2.7.10.6.6** Use of valid quantitative methods to measure outcomes against performance goals; **2.7.10.7** Include protocols for providing Case Management activities in a variety of settings, including, but not limited to an Enrollee's home, shelter, or other care setting; **2.7.10.8** Include criteria and protocols regarding documentation of follow-through with identification and successful linkage to community resources; **2.7.10.9** Include criteria and protocols for discharging Enrollees from Case Management; **2.7.10.10** Ensure that the Case Management activities each Enrollee is receiving are appropriately documented; **2.7.10.11** Ensure regular contacts between Case Management staff,	request of the Enrollee, their parent or legal guardian, or a member of the multi-disciplinary care team. **2.7.9** Multi-Disciplinary Care Team **2.7.9.1** The Contractor shall identify a multi-disciplinary care team to serve each Enrollee based on individual need for all Enrollees in Case Management ~~Tiers 2 and 3~~ and Transitional Case Management. The Contractor shall assign lead case managers based on an Enrollee's priority care needs, as identified through the POC. Where behavioral health is an Enrollee's primary health issue, the case manager shall be a behavioral health case manager. As needed, case managers with expertise in physical or behavioral health care will support lead case managers where there are secondary diagnoses. If the Enrollee is under the age of six (6), the lead case manager shall have expertise in early childhood mental health or access to a consultant with expertise in infant and early childhood mental health. **2.7.9.2** Physical and behavioral health case managers shall be co-located and based in Louisiana to allow for integration of Case Management for Enrollees with both physical and behavioral health care needs. The Contractor may request exceptions in writing to this requirement for individual case managers. **2.7.9.3** In addition to the case manager and the Enrollee and their family or Authorized Representative, the care team ~~shall~~ **may** include members based on an Enrollee's specific care needs**, preferences** and goals identified in the POC. The team may change over time as the Enrollee's care needs change. Potential team members ~~shall~~ **may** include, but are not limited to: **2.7.9.3.1** Primary care provider; **2.7.9.3.2** Behavioral health providers; **2.7.9.3.3** Specialists;	

	the Enrollee's PCP, the Enrollee's primary behavioral health provider as applicable, and the Enrollee; and **2.7.10.12** Include a process for graduation from Tiers 2 or 3 of Case Management to a lower tier, as an Enrollee's ongoing Case Management needs are reduced based on the Enrollee's POC. **2.7.11** Referrals for Tobacco Cessation and Problem Gaming **2.7.11.1** The HNA shall screen for problem gaming and tobacco usage. The case manager shall refer Enrollees who screen positive to appropriate Network Providers offering tobacco cessation treatment and/or problem gaming treatment services, including the Louisiana Tobacco Quitline. **2.7.11.2** Information regarding treatment services and/or referral to care shall be entered into the Contractor's systems for the purpose of tracking and reporting according to various demographics. Tobacco cessation and problem gaming reports shall be made available upon LDH request in a format and frequency as determined by LDH.	**2.7.9.3.4** Pharmacists; **2.7.9.3.5** Community health workers; **2.7.9.3.6** Home and community based service providers and managers; **2.7.9.3.7** Housing specialists, if the Enrollee is identified as homeless; and **2.7.9.3.8** State staff, including transition coordinators. **2.7.9.4** ~~Teams shall meet at regular intervals as identified in the POC, based on the individual's care needs. When possible, the team shall meet in person but when necessary, team members may participate in meetings via telephone. At a minimum, multi-disciplinary care teams shall meet on a monthly basis for Enrollees in Tier 3 Case Management and on a quarterly basis for Enrollees in Tier 2 Case Management.~~ **MDT meetings will occur as needed based on the individual's care needs and preferences.** **2.7.10** Case Management Policies and Procedures The Contractor shall develop, implement, and maintain criteria and protocols for determining which Case Management activities may benefit an Enrollee. The Contractor shall submit such criteria and protocols to LDH or its designee as part of Readiness Review and prior to any substantive revisions. Where the Contractor delegates Case Management to a Network Provider, the Contractor shall have a written plan in place for monitoring and oversight of performance under any such agreements, including provisions for assessing Provider compliance and corrective actions and/or termination as appropriate. The Contractor shall develop, implement, and maintain procedures for providing Case Management. Case Management procedures shall: **2.7.10.1** Be subject to approval by LDH in writing;	

		2.7.10.2 Include procedures for contacting Enrollees to complete the ~~HNA and~~ **Case Management** comprehensive assessment, including number of contact attempts and methods of contact; **2.7.10.3** Include procedures for acquiring and documenting Enrollee~~s'~~ **opting in the Case Management program and/or** consent (or the Enrollee's family or Authorized Representative) to receive Case Management and for the Contractor to share information about an Enrollee's care with Enrollee's providers to promote coordination and integration; **2.7.10.4** Include a plan describing how management of behavioral health services shall be integrated into the overall ~~care~~ **case** management of the Enrollee population; **2.7.10.5** Include criteria and protocols for ensuring appropriate staffing ratios and caseloads for case managers and other staff involved in ~~care~~ **case** management activities in line with industry practices; **2.7.10.6** Include processes for the Contractor to measure the effectiveness and quality of the Contractor's Case Management procedures. Such processes shall include: **2.7.10.6.1** Tracking of frequency and type of Case Management contact; **2.7.10.6.2** Developing and implementing inclusion criteria for ~~different tiers of~~ Case Management **programs**, including how the HNA and comprehensive assessment are utilized; **2.7.10.6.3** Determining expected outcomes in subgroups at ~~different tiers of~~ **in different** Case Management program**s**, including an impact analysis of Case Management on the use of the ED, inpatient admissions, and follow-up care; **2.7.10.6.4** Expected Case Management penetration and target rate of engagement; **2.7.10.6.5** Identification of relevant measurement processes or	

		outcomes; and **2.7.10.6.6** Use of valid quantitative methods to measure outcomes against performance goals; **2.7.10.7** Include protocols for providing Case Management activities in a variety of settings, including, but not limited to an Enrollee's home, shelter, or other care setting; **2.7.10.8** Include criteria and protocols regarding documentation of follow-through with identification and successful linkage to community resources; **2.7.10.9** Include criteria and protocols for discharging Enrollees from Case Management **programs**; **2.7.10.10** Ensure that the Case Management activities each Enrollee is receiving are appropriately documented; **2.7.10.11** Ensure regular contacts between Case Management staff, the Enrollee's PCP, the Enrollee's primary behavioral health provider as applicable, and the Enrollee; and **2.7.10.12** Include a process for graduation from ~~Tiers 2 or 3 of~~ **all** Case Management **programs** ~~to a lower tier,~~ as an Enrollee's ongoing case management needs are reduced based on the Enrollee's POC. ~~**2.7.11** Referrals for Tobacco Cessation and Problem Gaming~~ ~~**2.7.11.1** The HNA shall screen for problem gaming and tobacco usage. The case manager shall refer Enrollees who screen positive to appropriate Network Providers offering tobacco cessation treatment and/or problem gaming treatment services, including the Louisiana Tobacco Quitline.~~ ~~**2.7.11.2** Information regarding treatment services and/or referral to care shall be entered into the Contractor's systems for the purpose of tracking and reporting according to various demographics. Tobacco~~	

		~~cessation and problem gaming reports shall be made available upon LDH request in a format and frequency as determined by LDH.~~ **[subsequent items will be renumbered]**	
30	**2.8.3** Transitioning Between MCOs or FFS **[…]** **[new provision]**	**2.8.3** Transitioning Between MCOs or FFS **[…]** **2.8.3.4.2** **For newborns incorrectly enrolled, the relinquishing MCO is responsible for the newborn's hospitalization through date of discharge.** **[subsequent items will be renumbered]**	These revisions are necessary to end retroactive changes for newborn enrollment. This provision caused provider abrasion and is not required by federal law.
31	**2.9.2** Availability and Furnishing of MCO Covered Services **[…]** **2.9.2.1.1** Physical health providers who have submitted at least twenty-five (25) Claims in an office setting within the prior six (6) calendar months; **2.9.2.1.2** Behavioral health providers who have submitted at least twenty-five (25) Claims within the prior six (6) calendar months; or **2.9.2.1.3** Any providers who were newly contracted within the prior six (6) calendar months, regardless of Claim submissions.	**2.9.2** Availability and Furnishing of MCO Covered Services **[…]** **2.9.2.1.1** Physical health providers who have submitted at least ~~twenty-five (25)~~ **one (1)** Claim~~s~~ in an office setting within the prior ~~six (6)~~ **twelve (12)** calendar months; **2.9.2.1.2** Behavioral health providers who have submitted at least ~~twenty-five (25)~~ **one (1)** Claim~~s~~ within the prior ~~six (6)~~ **twelve (12)** calendar months; or **2.9.2.1.3** Any providers who were newly contracted within the prior ~~six (6)~~ **twelve (12)** calendar months, regardless of Claim submissions.	These revisions are necessary to update requirements related to Claim submissions.
32	**2.9.3** Timely Access to Care **[…]**	**2.9.3** Timely Access to Care **[…]**	These revisions are necessary to broaden the requirements outlined in Informational Bulletin 21-9 to include all providers, such

	2.9.3.6 If the Contractor or LDH identifies or anticipates that the network will not be sufficient to meet the timely access to care standards of this Contract for an MCO Covered Service in any location or for any population of Enrollees, the Contractor shall enhance its provider network in order to meet such standards. The Contractor should notify LDH of its strategy for enhancing its network and its contingency plan for connecting impacted Enrollees to care.	**2.9.3.6** If the Contractor or LDH identifies or anticipates that the network will not be sufficient to meet the timely access to care standards of this Contract for an MCO Covered Service in any location or for any population of Enrollees, the Contractor shall enhance its provider network in order to meet such standards. The Contractor should notify LDH of its strategy for enhancing its network and its contingency plan for connecting impacted Enrollees to care **which shall be made available upon LDH request in a format and frequency as determined by LDH**. **2.9.3.7 If LDH determines the Contractor has failed to ensure access to MCO covered services as defined in this contract and the MCO Manual for all enrollees, including failure to provide timely responses, LDH may require corrective action or impose other remedies for non-compliance.**	as hospitals, substance use residential facilities, therapeutic group homes, etc. The amendment also introduces a requirement for MCOs to monitor and track data for the purposes of reporting to LDH.
33	**2.9.5** Requests for Exceptions to Access Requirements **[…]** **2.9.5.4** As permitted by Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, and applicable Waivers, telemedicine may be used to facilitate access to MCO Covered Services by licensed professionals. Any MCO Covered Service provided via telemedicine must be medically necessary, and the procedure individualized, specific, and consistent with symptoms or confirmed diagnosis of an illness or injury under treatment, and not in excess of the Enrollee's needs. If the Contractor intends to utilize telemedicine to meet network adequacy requirements, the Contractor's telemedicine utilization must be approved by LDH in writing for this purpose. The Contractor may not utilize national telemedicine providers except in temporary or emergency situations (e.g., pandemics, natural disasters) if approved by LDH in writing.	**2.9.5** Requests for Exceptions to Access Requirements **[…]** **2.9.5.4** As permitted by Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, and applicable Waivers, telemedicine may be used to facilitate access to MCO Covered Services by licensed professionals. Any MCO Covered Service provided via telemedicine must be medically necessary, and the procedure individualized, specific, and consistent with symptoms or confirmed diagnosis of an illness or injury under treatment, and not in excess of the Enrollee's needs. If the Contractor intends to utilize telemedicine to meet network adequacy requirements, the Contractor's telemedicine utilization must be approved by LDH in writing for this purpose. ~~The Contractor may not utilize national telemedicine providers except in temporary or emergency situations (e.g., pandemics, natural disasters) if approved by LDH in writing.~~	This revision is necessary to allow the MCOs to use national telemedicine providers.

34	**2.9.7** Provider Participation **[…]** **2.9.7.5.10** Local Governing Entities; and **2.9.7.5.11** Providers that are actively serving the Contractor's Enrollees that are eligible under the Act 421 Children's Medicaid Option, subject to 42 CFR §431.52 and excluding ICF/IIDs.	**2.9.7** Provider Participation **[…]** **2.9.7.5.10** Local Governing Entities; ~~and~~ **2.9.7.5.11** Providers that are actively serving the Contractor's Enrollees that are eligible under the Act 421 Children's Medicaid Option, subject to 42 CFR §431.52 and excluding ICF/IIDs~~.~~**; and** **2.9.7.5.12 All Louisiana Crisis Response System (LaCRS) providers.**	These revisions are necessary to require the MCOs to contract with all LA Crisis Response System providers and to remove two provider types from the requirement.
35	**2.9.9** Other Enrollment and Disenrollment Requirements **[…]** **2.9.9.4** The Contractor shall require unlicensed staff of entities rendering and receiving reimbursement for Mental Health Rehabilitation (MHR) services to obtain and submit NPI numbers to the Contractor, as well as documentation verifying the unlicensed staff meets all qualifications and requirements for providing MHR services established by applicable Federal and State laws, rules, regulations, and the Medicaid Behavioral Health Service Provider Manual, inclusive of Evidence-Based Practice (EBP) MHR services, prior to reimbursing agencies for services provided by these staff. Claims submitted for MHR services shall include rendering provider NPIs and other Contractor required identifiers regardless of whether the rendering staff is licensed or unlicensed. The Contractor shall configure systems to deny Claims for services when rendering providers and NPIs are denoted on Claims for service that have not been credentialed and approved by the Contractor. The Contractor shall submit their policies and procedures associated with this requirement to LDH or its designee for approval during Readiness Review.	**2.9.9** Other Enrollment and Disenrollment Requirements **[…]** **2.9.9.4** ~~The Contractor shall require unlicensed staff of entities rendering and receiving reimbursement for Mental Health Rehabilitation (MHR) services to obtain and submit NPI numbers to the Contractor, as well as documentation verifying the unlicensed staff meets all qualifications and requirements for providing MHR services established by applicable Federal and State laws, rules, regulations, and the Medicaid Behavioral Health Service Provider Manual, inclusive of Evidence-Based Practice (EBP) MHR services, prior to reimbursing agencies for services provided by these staff. Claims submitted for MHR services shall include rendering provider NPIs and other Contractor required identifiers regardless of whether the rendering staff is licensed or unlicensed. The Contractor shall configure systems to deny Claims for services when rendering providers and NPIs are denoted on Claims for service that have not been credentialed and approved by the Contractor. The Contractor shall submit their policies and procedures associated with this requirement to LDH or its designee for approval during Readiness Review.~~ **Prior to reimbursing entities rendering and receiving reimbursement for Mental Health Rehabilitation (MHR) services, inclusive of Evidence-Based Practice (EBP) MHR services, the contractor shall:**	These revisions and new provisions are necessary to strengthens oversight of MHR services by requiring clear staff credentialing checkpoints as a result of findings from MCO network monitoring review to prevent retroactive verification errors.

		2.9.9.4.1 Ensure all MHRs: **2.9.9.4.1.1 Require all staff to obtain and submit NPI numbers to the Contractor,** **2.9.9.4.1.2 Ensure that all claims for MHR services include rendering provider NPIs and other Contractor required identifiers regardless of whether the rendering staff is licensed or unlicensed; and** **2.9.9.4.1.3 Submit documentation demonstrating compliance with all staff qualifications and requirements established by applicable Federal and State laws, rules, regulations, and the Medicaid Behavioral Health Service Provider Manual, prior to services being rendered.** **2.9.9.4.2 Collect and review documentation, prior to approving reimbursement for MHR services, of all required qualifications at:** **2.9.9.4.2.1 Credentialing;** **2.9.9.4.2.2 Upon hiring new staff; and** **2.9.9.4.2.3 During re-credentialing to maintain ongoing compliance;** **2.9.9.4.3 Implement claims processing system edits to deny claims for services when rendering provider NPIs appear on claims submissions but have not been verified and approved by the Contractor; and**	

		2.9.9.4.4 Submit policies and procedures associated with this requirement to LDH or its designee for approval during Readiness Review. **[subsequent items will be renumbered]**	
36	**2.9.9.6** The Contractor may not terminate Network Provider Agreements without cause during the period of forty-five (45) Calendar Days prior to the start of the Enrollment period through the last Calendar Day of the Enrollment Period.	~~**2.9.9.6** The Contractor may not terminate Network Provider Agreements without cause during the period of forty-five (45) Calendar Days prior to the start of the Enrollment period through the last Calendar Day of the Enrollment Period.~~ **[subsequent items will be renumbered]**	This revision is necessary to align with the ending of open enrollment.
37	**2.9.9.8** The Contractor shall receive written approval from LDH prior to terminating a Network Provider Agreement without cause when the provider is located in a Health Professional Shortage Area (HPSA). **2.9.9.9** When a Network Provider Agreement is terminated, with cause, the Contractor shall also provide to LDH its plan to notify the Contractor's Enrollees of such change, its strategy to ensure Timely access for Enrollees through different in-network and/or out-of-Network Providers, and its plan for ensuring that there will be no stoppage or interruption of services to Enrollees.	~~**2.9.9.8** The Contractor shall receive written approval from LDH prior to terminating a Network Provider Agreement without cause when the provider is located in a Health Professional Shortage Area (HPSA).~~ **2.9.9.9** When a Network Provider Agreement is terminated, with **or without** cause, the Contractor shall also provide to LDH its plan to notify the Contractor's Enrollees of such change, its strategy to ensure Timely access for Enrollees through different in-network and/or out-of-Network Providers, and its plan for ensuring that there will be no stoppage or interruption of services to Enrollees. **[subsequent items will be renumbered]**	This revision is necessary because HPSA designations are limited in areas making the termination requirement difficult.
38	**2.9.15** Access to Medication Assisted Treatment **[…]**	**2.9.15** Access to ~~Medication Assisted Treatment~~ **Medications for Opioid Use Disorder (MOUD)** **[…]**	These revisions are necessary to update to align with state statute.

	2.9.15.1 The Contractor shall ensure that substance use residential providers offer Medication Assisted Treatment (MAT) onsite or facilitate access to MAT offsite.	**2.9.15.1** The Contractor shall ensure that substance use residential providers offer **onsite access** to **Medication for Opioid Use Disorder (MOUD)** ~~Medication Assisted Treatment (MAT) onsite or facilitate access to MAT offsite~~ **in accordance with La. R.S. 40:2159.1. MOUD in this case is defined as at least one form of opioid antagonists (naltrexone oral/injectable) and at least one form of partial opioid agonists (buprenorphine oral/injectable).**	
39	**2.9.15** Access to Medication Assisted Treatment **[…]** **2.9.15.3** The Contractor shall be responsible for conducting Enrollee outreach and provider education and training regarding utilization of MAT to treat Opioid Use Disorder. This shall include, but not be limited to, assistance with Federal requirements to become a Drug Addiction Treatment Act of 2000 waivered physician to expand access to MAT services.	**2.9.15** Access to ~~Medication Assisted Treatment~~ **Medications for Opioid Use Disorder (MOUD)** **[…]** **2.9.15.3** The Contractor shall be responsible for conducting Enrollee outreach and provider education and training regarding utilization of ~~MAT~~ **MOUD** to treat Opioid Use Disorder. ~~This shall include, but not be limited to, assistance with Federal requirements to become a Drug Addiction Treatment Act of 2000 waivered physician to expand access to MAT services.~~	These revisions are necessary to update federal requirements and a waiver is no longer required to prescribe medication assisted treatment (MAT).
40	**2.9.25** Specialized Behavioral Health Providers **[…]** **2.9.25.32** The Contractor must work with crisis service providers and the LCH to schedule outpatient follow-up appointments via a warm handoff to support connection to ongoing care following a crisis episode.	**2.9.25** Specialized Behavioral Health Providers **[…]** **2.9.25.32** **After receiving notification from a crisis service provider or the LCH,** ~~T~~the Contractor ~~must work with crisis service providers and the LCH~~ **shall assist in** ~~to schedule~~ **coordinating** outpatient follow-up appointments ~~via a warm handoff~~ to support connection to ongoing care following a crisis episode.	New provisions are added in consideration of the 24-hour behavioral health crisis line and implementation of replacement with the Louisiana Crisis Hub (LCH).
41	**2.9.30** Credentialing and Re-credentialing of Providers and Clinical Staff **[…]** **2.9.30.7** The Contractor shall completely process credentialing	**2.9.30** Credentialing and Re-credentialing of Providers and Clinical Staff **[…]** **2.9.30.7** The Contractor shall completely process credentialing	These revisions are necessary due to the Office of Behavioral Health (OBH) has received repeated complaints regarding MCOs failing to notify providers when

	applications from all provider types within sixty (60) Calendar Days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed Network Provider Agreement. "Completely process" means that the Contractor shall: **[…]** **2.9.30.7.3** Review, approve and load approved applicants to its provider files in its Claims processing system; and **2.9.30.7.4** Submit on the weekly electronic Provider Directory to LDH or LDH's designee; or **2.9.30.7.5** Deny the application and assure that the provider is not used by the Contractor.	applications from all provider types within sixty (60) Calendar Days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed Network Provider Agreement**, complying with La. R.S. 46:460.61**. "Completely process" means that the Contractor shall: **[…]** **2.9.30.7.3** Review, approve and load approved applicants to its provider files in its Claims processing system~~; and~~ **2.9.30.7.4** **Comply with the provider notice requirements in accordance with La. R.S. 46:460.72(A) and** **2.9.30.7.5** Submit on the weekly electronic Provider Directory to LDH or LDH's designee; or **2.9.30.7.6** Deny the application**, notifying the provider of the adverse determination,** and assure that the provider is not used by the Contractor.	credentialing information is received, approved, or denied. References are made to La. R.S. 46:460.61 and La. R.S. 46:460.72(A), to ensure MCOs adhere to the entirety of the statues related to provider credentialing. The proposed contract amendment is intended to ensure that MCOs clearly and communicate the provider's status throughout the credentialing process.
42	**2.11.6** Claims Processing Requirements **2.11.6.1** At a minimum, the Contractor shall run one (1) provider payment cycle per week, on the same day each week, as determined by the Contractor.	**2.11.6** Claims Processing Requirements **2.11.6.1** At a minimum, the Contractor shall run one (1) provider payment cycle per week, on the same day each week, as determined by the Contractor. **For outpatient pharmacy claims, the Contractor shall run one (1) payment cycle per week, as determined by the Contractor.**	This revision is necessary to add clarification for pharmacy claims.
43	**2.11.17** Federal Responsibility for Payment for SBHS Provided to Enrollees Participating in Coordinated System of Care **[…]** **2.11.17.1** The CSoC contractor shall be responsible for payment to enrolled providers for the provision of SBHS, with the exception of PRTF, TGH,	**2.11.17** Federal Responsibility for Payment for SBHS Provided to Enrollees Participating in Coordinated System of Care **[…]** **2.11.17.1** The CSoC contractor shall be responsible for payment to enrolled providers for the provision of SBHS, with the exception of PRTF,	This revision is necessary to comply conversion of substance use service standards to the American Society of Addiction Medicine (ASAM) 4th Edition standards. This change is necessary to align contractual obligations with recent budget

	and SUD Residential treatment services (ASAM 3.1, 3.2-wm, 3.5 and 3.7 for children under 21 and Levels 3.3 and 3.7-wm for youth aged 21), for each month during which the Enrollee has a 1915(c)/1915(b)(3) Waiver segment on the eligibility file with a begin date on or earlier than the first (1st) Calendar Day of that month, or in the event that an Enrollee transfers between Waivers during the month, but the previous segment began on or earlier than the first (1st) Calendar Day of that month.	TGH, and SUD Residential treatment services ~~(ASAM 3.1, 3.2-wm, 3.5 and 3.7 for children under 21 and Levels 3.3 and 3.7-wm for youth aged 21)~~, for each month during which the Enrollee has a 1915(c)/1915(b)(3) Waiver segment on the eligibility file with a begin date on or earlier than the first (1st) Calendar Day of that month, or in the event that an Enrollee transfers between Waivers during the month, but the previous segment began on or earlier than the first (1st) Calendar Day of that month.	approval received to support statewide implementation of the updated ASAM criteria, effective January 1, 2026.
44	**2.11.17** Federal Responsibility for Payment for SBHS Provided to Enrollees Participating in Coordinated System of Care **[…]** **2.11.17.2** The CSoC contractor shall be responsible for payment to enrolled providers for the provision of SBHS through the last day of the month which includes the end date of the 1915(c)/1915(b)(3) segment on the eligibility file.	**2.11.17** Federal Responsibility for Payment for SBHS Provided to Enrollees Participating in Coordinated System of Care **[…]** **2.11.17.2** The CSoC contractor shall be responsible for payment to enrolled providers for the provision of SBHS through the last **Calendar Day** ~~day~~ of the month which includes the end date of the 1915(c)/1915(b)(3) segment on the eligibility file.	This revision is necessary to clarify the current language, but not change the requirement.
45	**2.11.17** Federal Responsibility for Payment for SBHS Provided to Enrollees Participating in Coordinated System of Care **[…]** **2.11.17.4** The Contractor shall be responsible for payment of all PRTF, TGH, and SUD Residential treatment services (ASAM Levels 3.1, 3.2-wm, 3.5 and 3.7 for children under 21 and Levels 3.3 and 3.7-wm for youth aged 21) for CSoC enrolled youth. **2.11.17.5** If an Enrollee no longer meets medical necessity criteria for a higher level of care (i.e., inpatient hospital) that was authorized by the CSoC contractor, and the Contractor has authorized PRTF, TGH, or SUD Residential treatment services (ASAM Levels 3.1, 3.2-wm, 3.5 and 3.7), but is unable to secure placement, the Contractor shall be responsible for assuming the continued authorization of, and payment for, the higher level service until placement is made, regardless of the Enrollee's CSoC Enrollment status,	**2.11.17** Federal Responsibility for Payment for SBHS Provided to Enrollees Participating in Coordinated System of Care **[…]** **2.11.17.4** The Contractor shall be responsible for payment of all PRTF, TGH, and SUD Residential treatment services ~~(ASAM Levels 3.1, 3.2-wm, 3.5 and 3.7 for children under 21 and Levels 3.3 and 3.7-wm for youth aged 21)~~ for CSoC enrolled youth. **2.11.17.5** If an Enrollee no longer meets medical necessity criteria for a higher level of care (i.e., inpatient hospital) that was authorized by the CSoC contractor, and the Contractor has authorized PRTF, TGH, or SUD Residential treatment services ~~(ASAM Levels 3.1, 3.2-wm, 3.5 and 3.7)~~, but is unable to secure placement, the Contractor shall be responsible for assuming the continued authorization of, and payment for, the higher level service until placement is made, regardless of the	These revisions are necessary to comply conversion of substance use service standards to the American Society of Addiction Medicine (ASAM) 4th Edition standards. This change is necessary to align contractual obligations with recent budget approval received to support statewide implementation of the updated ASAM criteria, effective January 1, 2026.

	unless the Child and Family Team (CFT) agrees that the Enrollee's behavioral health and/or medical condition is stable enough for the Enrollee to be safely discharged home, and the CFT has made a plan to support the Enrollee and family with outpatient care until placement in residential treatment is secured.	Enrollee's CSoC Enrollment status, unless the Child and Family Team (CFT) agrees that the Enrollee's behavioral health and/or medical condition is stable enough for the Enrollee to be safely discharged home, and the CFT has made a plan to support the Enrollee and family with outpatient care until placement in residential treatment is secured.	
46	**2.12.2 Utilization Management Committee** **2.12.2.2** The UM Committee shall provide utilization review and monitoring of UM activities of both the Contractor and its providers and is directed by the Contractor's Medical Director. The UM Committee shall convene no less than quarterly and shall make meeting minutes available to LDH upon request. LDH representatives, as appointed by LDH, shall be included as members of the UM Committee, if requested. UM Committee responsibilities include:	**2.12.2 Utilization Management Committee** ~~**2.12.2.2** The UM Committee shall provide utilization review and monitoring of UM activities of both the Contractor and its providers and is directed by the Contractor's Medical Director. The UM Committee shall convene no less than quarterly and shall make meeting minutes available to LDH upon request. LDH representatives, as appointed by LDH, shall be included as members of the UM Committee, if requested.~~ UM Committee responsibilities include:	The revision is necessary to allow the MCO to have more control over their UM Committee.
47	**2.12.6.1** Standard Service Authorization **[…]** **2.12.6.1.2** All standard Service Authorization determinations shall be made no later than fourteen (14) Calendar Days following receipt of the request for service.	**2.12.6.1** Standard Service Authorization **[…]** **2.12.6.1.2** All standard Service Authorization determinations shall be made no later than ~~fourteen (14)~~ **seven (7)** Calendar Days following receipt of the request for service.	This revision is necessary to comply with CMS Interoperability and prior authorization requirements.
	2.12.6.4.1 Service Authorization Approvals **2.12.6.4.1.1** For Service Authorization approval for a non-emergency admission, procedure or service, the Contractor shall notify the provider verbally or as expeditiously as the Enrollee's health condition requires but not more than one (1) Business Day of making the initial determination and provide written notification to the provider within two (2) Business Days of making the determination.	**2.12.6.4.1** Service Authorization Approvals **2.12.6.4.1.1** For Service Authorization approval for a non-emergency admission, procedure or service, the Contractor shall notify the provider ~~verbally or~~ as expeditiously as the Enrollee's health condition requires but not more than one (1) Business Day of making the initial determination and provide written notification to the provider within two (2) Business Days of making the determination.	This revision is to allow the MCO to notify the provider by any means necessary to meet the requirement.
48	**2.12.6.4.2** Adverse Action	**2.12.6.4.2** Adverse Action **[…]**	These revisions are needed to comply with requirements contained in the

	[…] **2.12.6.4.2.2** The Contractor shall notify the requesting provider of a determination to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. The Contractor shall provide written notification to the provider rendering the service, whether a health care professional or facility or both, within two (2) Business Days of making the determination.	**2.12.6.4.2.2** The Contractor shall notify the requesting provider of a determination to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested **and include the denial reason**. The Contractor shall provide written notification to the provider rendering the service, whether a health care professional or facility or both, within two (2) Business Days of making the determination.	Interoperability and Prior Authorization rule. This requirement is effective 1/1/26.
49	**2.12.2.2** The UM Committee shall provide utilization review and monitoring of UM activities of both the Contractor and its providers and is directed by the Contractor's Medical Director. The UM Committee shall convene no less than quarterly and shall make meeting minutes available to LDH upon request. LDH representatives, as appointed by LDH, shall be included as members of the UM Committee, if requested. The UM Committee responsibilities include:	**2.12.2.2** ~~The UM Committee shall provide utilization review and monitoring of UM activities of both the Contractor and its providers and is directed by the Contractor's Medical Director. The UM Committee shall convene no less than quarterly and shall make meeting minutes available to LDH upon request. LDH representatives, as appointed by LDH, shall be included as members of the UM Committee, if requested.~~ The UM Committee responsibilities include:	LDH is giving more autonomy to the MCO to conduct UM management as they see fit.
50	**[new provision]**	**2.12.9 Gold Card Program for Providers** **2.12.9.1 The Contractor shall establish and implement a Gold Card Program designed to recognize and incentivize high-performing providers who demonstrate consistent quality of care, compliance with clinical guidelines, and efficiency in service delivery.** **2.12.9.2 Provider Eligibility. The Contractor shall develop and maintain written criteria for designation as a Gold Card Provider. Such criteria may include, but are not limited to:** **2.12.9.2.1 Demonstrated adherence to evidence-based clinical protocols;** **2.12.9.2.2 Favorable utilization review outcomes;**	This addition is to recognize and incentive high performing providers.

		2.12.9.2.3 Timely and accurate submission of claims; and **2.12.9.2.4 Positive performance on applicable quality and outcome measures.** **2.12.9.3 Program Benefits. The Contractor may extend streamlined administrative processes to Gold Card Providers, which may include, but are not limited to reduced or waived prior authorization requirements;** **2.12.9.4 Duration and Review. Gold Card designation shall remain in effect for a period determined by the Contractor, subject to periodic review and renewal based on continued provider performance. The Contractor reserves the right to revoke or suspend Gold Card status if a provider no longer meets eligibility requirements or engages in conduct inconsistent with Program objectives.** **2.12.9.5 Notice to Providers. The Contractor shall provide written notice to providers of their eligibility, designation, or removal from the Gold Card Program, including the basis for such determination.** **2.12.9.6 A Gold Card Program proposal must be submitted to LDH for approval by March 1, 2026 for an effective date of July 1, 2026.** **[subsequent items will be renumbered]**	

51	**2.12.9 Health Record Review** **[…]** **2.12.9.2** The Contractor shall maintain a written strategy for conducting health record reviews, reporting results and the corrective action process. The strategy shall be provided to LDH or its designee for approval as part of Readiness Review and sixty (60) Calendar Days prior to the implementation of any updates. The strategy shall include, at a minimum, the following: **2.12.9.2.1** Designated staff to perform this duty; **2.12.9.2.2** The method of case selection; **2.12.9.2.3** The anticipated number of reviews by practice site; **2.12.9.2.4** The tool the Contractor shall use to review each site; **2.12.9.2.5** How the Contractor shall link the information compiled during the review to other Contractor functions (e.g. quality improvement [QI], credentialing, peer review, etc.); and **2.12.9.2.6** Schedule of reviews by provider type.	**2.12.9 Health Record Review** **[…]** ~~**2.12.9.2** The Contractor shall maintain a written strategy for conducting health record reviews, reporting results and the corrective action process. The strategy shall be provided to LDH or its designee for approval as part of Readiness Review and sixty (60) Calendar Days prior to the implementation of any updates. The strategy shall include, at a minimum, the following:~~ ~~**2.12.9.2.1** Designated staff to perform this duty;~~ ~~**2.12.9.2.2** The method of case selection;~~ ~~**2.12.9.2.3** The anticipated number of reviews by practice site;~~ ~~**2.12.9.2.4** The tool the Contractor shall use to review each site;~~ ~~**2.12.9.2.5** How the Contractor shall link the information compiled during the review to other Contractor functions (e.g. quality improvement [QI], credentialing, peer review, etc.); and~~ ~~**2.12.9.2.6** Schedule of reviews by provider type.~~ **[subsequent items will be renumbered]**	This is no longer needed due to MCOs having access to providers EMR systems to conduct these reviews and do not need to collect paper records to conduct these reviews.
52	**2.12.12** PRTF Requirements **[…]** **2.12.11.1.1** When a referring party requests PRTF for an Enrollee, the Contractor shall perform an initial screen upon receipt of referral including review of records and current clinical information to determine whether PRTF is an appropriate level of care, or if alternate community-based services could meet the referral needs. The screen shall be completed within twenty-four (24) hours of the Contractor's receipt of the referral and all clinical	**2.12.12** PRTF Requirements **[…]** **2.12.12.1.1** When a referring party requests PRTF for an Enrollee, the Contractor shall perform an initial screen upon receipt of referral including review of records**, inclusive of MCO records of the history of outpatient and inpatient treatment authorizations and services, records the MCO has requested and obtained from treatment providers for which the MCO was the payer,** and current clinical information to determine whether PRTF is an appropriate level of care,	These revisions are necessary to ensure MCO care management. When determining medical necessity for PRTF level of care, MCO shall consider records submitted to the MCO by the referring party, and the MCO shall also review records that the MCO already has access to.

	information needed and requested by the Contractor to make the determination.	or if alternate community-based services could meet the referral needs. **If a parent, guardian, or referring party initially submits information lacking in sufficient detail to make a determination of medical necessity, the MCO shall make a request for the necessary information and/or documentation and allow time for satisfaction of the request prior to issuing a denial**. The screen shall be completed within twenty-four (24) hours of the Contractor's receipt of the referral and all clinical information needed and requested by the Contractor to make the determination. **[subsequent items will be renumbered]**	The MCO may already have information that would support PRTF level of care, and the MCO shall review and consider existing clinical data in addition to anything produced by the referring party.
53	2.12.12 PRTF Requirements **[…]** **2.12.11.1.3** If PRTF placement is denied, the Contractor shall immediately notify the Enrollee and/or guardian and, with consent, the referring party requesting PRTF services and, within forty-eight (48) hours, provide written notification of the denial. The notification of denial shall include information on alternative services that may meet the Enrollee's needs to ensure health and safety, including information on available providers of those services, the right of the Enrollee to Appeal the denial, and the process to do so.	**2.12.12** PRTF Requirements **[…]** **2.12.12.1.3** If PRTF placement is denied, the Contractor shall immediately notify the Enrollee and/or guardian and, with consent, the referring party requesting PRTF services and, within forty-eight (48) hours, provide written notification of the denial. The notification of denial shall include information on alternative services that may meet the Enrollee's needs to ensure health and safety, including information on available providers of those services, the right of the Enrollee to Appeal the denial, and the process to do so. **When a PRTF denial is issued for a youth currently in an out-of-home setting (including but not limited to hospital or detention), upon issuing the denial the MCO shall at the same time initiate contact with the parent/guardian, referring party, and current treating provider to coordinate, gain consent, and arrange for the recommended alternative services, to ensure continuity of care.** **[subsequent items will be renumbered]**	The revisions are necessary to reduce delays in access to care. If an MCO receives insufficient information to make a MNC determination, and issues a denial of PRTF LOC, then the timeline for an appeal begins, which allows the MCO to take an additional 30 days to make a determination. The 30 days prior to a decision on the appeal, causes delays in care. Instead, if the MCO notes that the information provided is insufficient to make an MNC decision, it is better member care to request the additional information needed so that it can be considered in the decision, rather than denying which then results in a 30-day delay in reconsideration on appeal.

54	**2.13.4** Welcome Calls **[…]** **[added Health Needs Assessment section to Welcome Calls section from Case Management section]**	**2.13. 4** Welcome Calls **[…]** **2.13.4.5 Health Needs Assessment** **2.13.4.5.1 The Contractor shall attempt to conduct Enrollee Health Needs Assessments (HNA) as part of the Enrollee welcome call to identify health and functional needs of Enrollees, and to identify Enrollees who require short-term care coordination or Case Management for medical, behavioral or social needs. When an Enrollee is a child, the HNA shall be completed by the Enrollee's parent or legal guardian.** **2.13.4.5.2 The Contractor shall develop, implement, and maintain procedures for completing an initial HNA for each Enrollee, and shall make best efforts to complete such screening within ninety (90) Calendar Days of the Enrollee's effective date of Enrollment [42 CFR §438.208(b)]. If the initial HNA attempt is unsuccessful, the Contractor shall attempt to conduct, and document its efforts to conduct, the HNA on at least three (3) different occasions, at different times of the day and on different days of the week.** **2.13.4.5.3 The Contractor shall provide HNA data to the Enrollee's assigned PCP, and to LDH as requested.** **2.13.4.5.4 The Contractor's HNA shall:** **2.13.4.5.4.1 Utilize a common survey-based instrument, which shall be developed by LDH as described in Part 3: State Responsibilities;** **2.13.4.5.4.2 Be made available to Enrollees in multiple formats including web-based, print, and telephone;**	This revision is needed to relocate the Health Needs Assessment section to a new section of the contract.

		2.13.4.5.4.3 Be conducted with the consent of the Enrollee; **2.13.4.5.4.4 Identify individuals for referral to Case Management;** **2.13.4.5.4.5 Screen for needs relevant to priority social determinants of health as described in the Population Health and Social Determinants of Health section; and** **2.13.4.5.4.6 Include disclosures of how information will be used.**	
55	**2.13.6.6** Welcome Newsletter […] **2.13.6.6.3.4** Contractor service hours and availability with contact information including, but not limited to, Enrollee Services, Nurse Line, Behavioral Health Crisis Line, reporting suspected Fraud and Abuse, Pharmacy Benefits Manager, and any Subcontractor providing MCO Covered Services or Value-Added Benefits;	**2.13.6.6** Welcome Newsletter […] **2.13.6.6.3.4** Contractor service hours and availability with contact information including, but not limited to, Enrollee Services, Nurse Line, ~~Behavioral Health Crisis Line~~, reporting suspected Fraud and Abuse, Pharmacy Benefits Manager, and any Subcontractor providing MCO Covered Services or Value-Added Benefits;	This revision is necessary to align with the Louisiana Crisis Hub.
56	**2.13.8** Provider Directory for Enrollees **[…]** **2.13.8.7.1.1** The hard copy and online Provider Directories shall not include Network Providers who have submitted no Claims within the six (6) calendar months prior to publication, unless the Network Provider was newly contracted during this six (6) month period; **2.13.8.7.2** Names, group affiliations, street addresses, telephone numbers, website URLs, specialties, whether the provider is accepting new Enrollees, and cultural and linguistic capabilities by current Network Providers by each provider type specified in this Contract. Cultural and linguistic capabilities shall include languages offered by the provider or a skilled medical	**2.13.8** Provider Directory for Enrollees **[…]** ~~**2.13.8.7.1.1** The hard copy and online Provider Directories shall not include Network Providers who have submitted no Claims within the six (6) calendar months prior to publication, unless the Network Provider was newly contracted during this six (6) month period;~~ **2.13.8.7.2** Names, group affiliations, street addresses, telephone numbers, website URLs, specialties, whether the provider is accepting new Enrollees, **whether the provider offers covered services via telehealth** and cultural and linguistic capabilities by current Network Providers by each provider type specified in this Contract. Cultural and	These revisions are necessary to remove a requirement and align with CMS guidelines.

	interpreter at the provider's office, and whether the provider has completed cultural competency training. The Provider Directory shall also indicate whether the Network Provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment;	linguistic capabilities shall include languages offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competency training. The Provider Directory shall also indicate whether the Network Provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment;	
57	**2.13.13** Automated Call Distribution (ACD) System **[…]** **2.13.13.7** Measure the total number of calls and average calls handled per day/week/month; **2.13.13.8** Measure the average hours of use per day;	**2.13.13** Automated Call Distribution (ACD) System **[…]** **2.13.13.7** Measure the total number of calls and average calls handled per **Business** day/week/month; **2.13.13.8** Measure the average hours of use per **Business** day;	These revisions are necessary to clarify the current language, but not change the requirement.
58	**2.14.2** Prohibited Marketing Activities **[…]** **2.14.2.12** Marketing or distributing Marketing Materials, including Member Handbooks, and soliciting Enrollees in any other manner, inside, at the entrance or within one hundred (100) feet of check cashing establishments, public assistance offices, DCFS eligibility offices for the Supplemental Nutrition Assistance Program (SNAP), FITAP, Health Units, Louisiana Medicaid Program Eligibility Offices, and/or certified Medicaid Application Centers without prior approval from LDH;	**2.14.2** Prohibited Marketing Activities **[…]** **2.14.2.12** Marketing or distributing Marketing Materials, including Member Handbooks, and soliciting Enrollees in any other manner, inside, at the entrance or within one hundred (100) feet of ~~check cashing establishments, public assistance offices, DCFS eligibility offices for the Supplemental Nutrition Assistance Program (SNAP), FITAP, Health Units~~, Louisiana Medicaid Program Eligibility Offices, and/or certified Medicaid Application Centers without prior approval from LDH;	This revision is necessary to give the MCOs more flexibility in marketing.
59	**2.16.1** General Requirements **[…]** **2.16.1.3.5** QM/QI requirements of this Contract applied to the delivery of both physical health services and behavioral health services.	**2.16.1** General Requirements **[…]** **2.16.1.3.5** QM/QI requirements of this Contract applied to the delivery of ~~both~~ physical health services**,** behavioral health services, **and applied behavior analysis**.	This revision is necessary to include applied behavior analysis with physical health and behavioral health in order to require the MCO to continue quality reviews.

60	**2.17 Value-Based Payment** **2.17.1** Value-Based Payment (VBP) Overview The Contractor shall develop and implement a VBP Strategic Plan for achieving the performance benchmarks in this Contract and paying providers based on performance. The Contractor's VBP strategy shall pertain to measurable outcomes that are meant to improve the health of populations (better health), enhance the experience of care for individuals (better care), effectively manage Louisiana Medicaid Program per capita care costs (lower costs), and be designed to meet or exceed the VBP withhold requirements in this Contract. In developing its VBP Strategic Plan, the Contractor shall refer to this Contract, the MCO Manual and the Alternative Payment Method (APM) Framework developed by the Health Care Payment Learning and Action Network (HCP-LAN). **2.17.2** Minimum VBP Threshold and Qualifying VBP Arrangements A portion of the Contractor's annual VBP withhold described in the Financial Incentives for MCO Performance section shall be tied to the Contractor's demonstration that it has met the minimum VBP threshold established as defined by LDH in accordance with this Contract. Unless otherwise modified by LDH, the minimum VBP threshold for each Measurement Year is as described in the Financial Incentives for MCO Performance section.	**2.17 Value-Based Payment** **2.17.1** Value-Based Payment (VBP) Overview The Contractor shall develop and implement a VBP Strategic Plan for achieving the performance benchmarks in this Contract and paying providers based on performance. The Contractor's VBP strategy shall pertain to measurable outcomes that are meant to improve the health of populations (better health), enhance the experience of care for individuals (better care), effectively manage Louisiana Medicaid Program per capita care costs (lower costs)~~., and be designed to meet or exceed the VBP withhold requirements in this Contract.~~ In developing its VBP Strategic Plan, the Contractor shall refer to this Contract, the MCO Manual and the Alternative Payment Method (APM) Framework developed by the Health Care Payment Learning and Action Network (HCP-LAN). ~~**2.17.2** Minimum VBP Threshold and Qualifying VBP Arrangements~~ ~~A portion of the Contractor's annual VBP withhold described in the Financial Incentives for MCO Performance section shall be tied to the Contractor's demonstration that it has met the minimum VBP threshold established as defined by LDH in accordance with this Contract. Unless otherwise modified by LDH, the minimum VBP threshold for each Measurement Year is as described in the Financial Incentives for MCO Performance section.~~ **[subsequent items will be renumbered]**	These revisions are necessary to align with the policy change that LDH no longer wants a withhold for VBP.
61	**2.20** Fraud, Waste, and Abuse Prevention **…** **2.20.1.4** The Contractor and its providers and Subcontractors shall	**2.20** Fraud, Waste, and Abuse Prevention **…** **2.20.1.4** The Contractor and its providers and Subcontractors shall	These revisions are necessary to provide additional clarification that redacted records are not considered compliant for

	make all program and financial records and service delivery sites open to the representative or any designees of the above upon request. HHS, OIG, LDH, GAO, LLA, the Office of the Attorney General, and/or the designees of any of the above shall have Timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with Contractor clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. **2.20.1.5** The Contractor and its providers and Subcontractors shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested. If a provider fails to respond to a request from the Contractor and/or fails to supply the requested record or information to the Contractor, the Contractor shall place the provider on a payment suspension or payment withhold until the record or information is produced or the provider notifies the Contractor in writing that the record or information cannot be produced.	make all program and financial records and service delivery sites open to the representative or any designees of the above upon request. HHS, OIG, LDH, GAO, LLA, the Office of the Attorney General, and/or the designees of any of the above shall have Timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with **any and all** Contractor clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. **The records provided for review shall be non-redacted.** **2.20.1.5** The Contractor and its providers and Subcontractors shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested **and shall not be redacted.** If a provider fails to respond to a request from the Contractor and/or **fails to substantially comply with** ~~supply~~ the requested record**(s)** or information **from** ~~to~~ the Contractor, the Contractor shall place the provider on a payment suspension or payment withhold until the record**(s)** or information is produced or the provider notifies the Contractor in writing that the record or information cannot be produced.	record requests from law enforcement and/or oversight agencies.
62	**2.20** Fraud, Waste, and Abuse Prevention **[…]** **2.20.1.7** The Contractor shall certify all statements, reports and Claims, financial and otherwise, as true, accurate, and complete. The Contractor shall not submit for payment purposes those Claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, Waivers, the Contract, and	**2.20** Fraud, Waste, and Abuse Prevention **[…]** **2.20.1.7** The Contractor shall certify all statements, reports and Claims, financial and otherwise, as true, accurate, **non-redacted** and complete. The Contractor shall not submit for payment purposes those Claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan,	This revision is necessary to provide additional clarification that redacted records are not considered compliant for record requests from law enforcement and/or oversight agencies.

	the MCO Manual.	Waivers, the Contract, and the MCO Manual.	
63	**2.20** Fraud, Waste, and Abuse Prevention **[…]** **2.20.1.12.2.4** All confirmed or suspected provider Fraud and Abuse shall immediately be reported in writing to LDH Program Integrity and MFCU; and **2.20.1.12.2.5** All confirmed or suspected Enrollee Fraud and Abuse shall be reported immediately, in writing, to LDH Program Integrity and local law enforcement of the Enrollee's parish of residence. **2.20.1.12.3** When making a referral of suspected Fraud, the Contractor shall utilize the **LDH Provider Fraud Referral Form** available in the **MCO Manual**. **2.20.1.12.4** The Contractor shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed Fraud and Abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting Fraud or suspected Fraud and/or suspected Abuse and/or confirmed Abuse, the Contractor shall not take any of the following actions as they specifically relate to Louisiana Medicaid Program Claims:	**2.20** Fraud, Waste, and Abuse Prevention **[…]** **2.20.1.12.2.4** All confirmed or suspected provider Fraud and Abuse shall ~~immediately~~ be reported in writing to LDH Program Integrity and MFCU **within forty-eight (48) hours**; and **2.20.1.12.2.5** All confirmed or suspected Enrollee Fraud and Abuse shall be reported ~~immediately~~, in writing, to LDH Program Integrity and local law enforcement of the Enrollee's parish of residence **within forty-eight (48) hours**. **2.20.1.12.3** When making a referral of suspected **or confirmed** Fraud **and Abuse**, the Contractor shall utilize the **LDH Provider Fraud Referral Form** available in the **MCO Manual**. **2.20.1.12.4** The Contractor shall promptly perform a preliminary investigation of all ~~incidents of suspected~~ **allegations, tips, or complaints** ~~and/or~~ **of** ~~confirmed~~ Fraud and Abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting Fraud or suspected Fraud and/or suspected Abuse and/or confirmed Abuse, the Contractor shall not take any of the following actions as they specifically relate to Louisiana Medicaid Program Claims:	These revisions are necessary to provide additional clarification that the MCOs must use the Fraud Referral Form to refer any issue of fraud or abuse to LDH and MFCU, rather than deciding whether an issue is simply a "notice. " LDH is removing all references to fraud "notices" from the contracts.
64	**2.20** Fraud, Waste, and Abuse Prevention **[…]** **2.20.1.12.6** The Contractor and its Subcontractors shall seek to reduce prospective financial loss to health Fraud, Waste, and Abuse when fraudulent and/or criminal activity is suspected through pre-payment or post-payment review, audit or investigation.	**2.20** Fraud, Waste, and Abuse Prevention **[…]** **2.20.1.12.6** The Contractor and its Subcontractors shall seek to reduce prospective financial loss to health Fraud, Waste, and Abuse when fraudulent and/or criminal activity is suspected through pre-payment **reviews and/**or post-payment reviews, audits or investigation**s**.	This revision is necessary to clarify that Act No. 534 of the 2022 Regular Session ensure LDH approval is obtained for any pre-payment review.

65	**2.20** Fraud, Waste, and Abuse Prevention **[…]** **2.20.1.12.6.2** Pursuant to La. R.S. 46:460.76, Pre-Payment Review shall be limited to requirements that are implemented directly by LDH and in accordance with the provisions of the Medical Assistance Programs Integrity Law, La. R.S. 46:437.1 et seq. The Contractor shall submit a request to LDH for written approval prior to subjecting a Network Provider or Out-of-Network Provider to Pre-Payment Review**.**	**2.20** Fraud, Waste, and Abuse Prevention **[…]** **2.20.1.12.6.2** Pursuant to La. R.S. 46:460.76, Pre-Payment Review shall be limited to requirements that are implemented directly by LDH and in accordance with the provisions of the Medical Assistance Programs Integrity Law, La. R.S. 46:437.1 et seq. ~~The Contractor shall submit a request to LDH for written approval prior to subjecting a Network Provider or Out-of-Network Provider to Pre-Payment Review.~~	The revision is necessary to comply with the provision of state law.
66	**2.20** Fraud, Waste, and Abuse Prevention **[…]** **2.20.1.13** The Contractor and/or Subcontractors shall include in all of its Network Provider Agreements a provision requiring, as a condition of receiving any amount of Louisiana Medicaid Program payment, that the provider complies with this Section of the Contract**.**	**2.20** Fraud, Waste, and Abuse Prevention **[…]** **2.20.1.13** The Contractor and/or Subcontractors shall include in all of its Network Provider Agreements a provision ~~requiring, as a condition of receiving any amount of Louisiana Medicaid Program payment, that the provider complies with this Section of the Contract.~~ **(1) notifying the provider that the payment of any claims are from federal and state funds; (2) the provider is required to adhere to all standards and requirements related to the provision of services paid in whole or part by the Medicaid program; (3) the provider is required to adhere to all federal and state statutes, regulations and contractual provisions governing the conduct of providers within the Medicaid program, including but not limited to the FCA, MAPIL, SURS regulations, and Part 2.20 of this contract; (4) when submitting claims the provider is certifying the claim is true and correct in all material aspects of the claim and is supported by adequate documentation, and (5) requiring, as a condition of receiving any amount of Louisiana Medicaid Program payment, that the provider complies with this Section of the Contract.**	This revision is necessary to provide additional clarification related to source of funding, specifically that Federal and State government funding through Medicaid carries certain obligations by law, including that by submitting a claim for payment, the provider is certifying the claim is correct and true.

67	**2.20** Fraud, Waste, and Abuse Prevention **[…]** **2.20.2.2.15** Procedures for prompt reporting to the State of all overpayments identified and recovered, specifying the overpayments due to potential Fraud.	**2.20** Fraud, Waste, and Abuse Prevention **[…]** **2.20.2.2.15** Procedures for ~~prompt~~ reporting **within 30 calendar days** to the State ~~of~~ all overpayments identified and recovered, specifying the overpayments due to potential Fraud.	This revision is necessary to update guidance from CMS. CMS revised 42 CFR 438.608(a)(2) from "prompt" to reporting "within 30 calendar days."
68	**2.20.5** Reporting **[…]** **2.20.5.1** The Contractor and its Subcontractors shall be responsible for promptly reporting suspected Fraud, Waste, Abuse, and neglect information to the Louisiana Office of Attorney General MFCU and LDH as soon as practical after discovering suspected incidents, but no later than three (3) Business Days, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).	**2.20.5** Reporting **[…]** **2.20.5.1** The Contractor and its Subcontractors shall be responsible for promptly reporting suspected **or confirmed** Fraud, Waste, Abuse, and neglect information to the Louisiana Office of Attorney General MFCU and LDH ~~as soon as practical~~ **within forty-eight (48) hours** after discovering suspected incidents, ~~but no later than three (3) Business Days,~~ taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).	This revision is to provide clarification regarding the reporting of Fraud, Waste, Abuse (FWA) to the LDH and MFCU.
69	**2.20.5** Reporting **[…]** **2.20.5.4.3** For each complaint that warrants full investigation conducted in accordance with 42 CFR §455.15 and §455.16, the Contractor shall provide LDH, at a minimum, the following:	**2.20.5** Reporting **[…]** **2.20.5.4.3** For each complaint that **resulted in the Contractor conducting a** ~~warrants~~ full investigation ~~conducted~~ in accordance with 42 CFR §455.15 and §455.16, the Contractor shall provide LDH, at a minimum, the following:	This revision is necessary to include The MCO would only conduct a full investigation to of a fraud/abuse complaint if MFCU declined the referral or allowed the MCO to proceed.
70	**2.20.5** Reporting **[…]** **2.20.5.5** The Contractor shall report to LDH Program Integrity quarterly all audits performed and overpayments identified and recovered by the Contractor and all of its Subcontractors. [See 42 CFR §438.608(d)(3).]	**2.20.5** Reporting **[…]** **2.20.5.5** The Contractor shall report to LDH Program Integrity **monthly and** quarterly all audits performed and overpayments identified and recovered by the Contractor and all of its Subcontractors. [See 42 CFR §438.608(d)(3).]	This revision is necessary to update guidance from CMS. CMS revised 42 CFR 438.608(a)(2) from "prompt" to reporting "within 30 calendar days."

71	**2.20.6** Rights of Review and Recovery by Contractor and LDH **[…]** **2.20.6.3** The Contractor and its Subcontractors shall have the right to audit, review and investigate providers and Enrollees within the Contractor's network for a five (5) year period from the date of service of a Claim via "complex" review. A complex review is one for which the review of medical, financial, and/or other records, including those onsite, were necessary to determine the existence of an improper payment. The collected funds from the Contractor's complex reviews are to remain with the Contractor.	**2.20.6** Rights of Review and Recovery by Contractor and LDH **[…]** **2.20.6.3** The Contractor and its Subcontractors shall have the right to audit, review and investigate providers and Enrollees within the Contractor's network for a five (5) year period from the date of service of a Claim via "complex" review. A complex review is one for which the review of medical, financial, and/or other records, including those onsite, were necessary to determine the existence of an improper payment. **In determining the amount of an overpayment during a complex review, the Contractor and its Subcontractors shall give consideration for the amount the Medicaid program would have paid had the provider billed the claim correctly.** The collected funds from the Contractor's complex reviews are to remain with the Contractor.	Revisions are necessary to address instances where the MCO determines an overpayment. They can do a whole take back rather than a differential analysis on what was paid versus what was properly payable. When determining damages, MAPIL requires a differential analysis (see La. R.S. 46:438.6) and this added provision is intended to align with MAPIL.
72	**2.20.6** Rights of Review and Recovery by Contractor and LDH **[…]** **2.20.6.4** All complex reviews shall be completed within ten (10) months (three hundred (300) Calendar Days) of the date the case was opened unless an extension is authorized by LDH. This review period is inclusive of all provider notifications, health plan document reviews, and includes any Provider Appeal or rebuttal process.	**2.20.6** Rights of Review and Recovery by Contractor and LDH **[…]** **2.20.6.4** All complex reviews shall be completed within ~~ten~~ **one** (1~~0~~) **year** ~~months~~ (three hundred **sixty-five** (365~~00~~) Calendar Days) of the date the case was opened unless an extension is authorized by LDH. This review period is inclusive of all provider notifications, health plan document reviews, and includes any Provider Appeal or rebuttal process.	Revisions are necessary to change to give the MCOs more time to properly work their cases and also account for the increase in MFCU response time from 14 days to 30 days.
73	**2.20.6** Rights of Review and Recovery by Contractor and LDH **[…]** **2.20.6.6** LDH or its designee will notify the Contractor when it is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or Claims upon which the recoupment or withhold are based meet one (1) or more of the following criteria:	**2.20.6** Rights of Review and Recovery by Contractor and LDH **[…]** **2.20.6.6** LDH or its designee will notify the Contractor when it is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or Claims upon which the recoupment or withhold are based meet ~~one (1) or more~~ of the following criteria:	This revision is necessary to clarify the current language, but not change the requirement.

74	**2.20.6** Rights of Review and Recovery by Contractor and LDH **[…]** **2.20.6.8** Contact with a provider shall be prohibited in instances resulting from suspected Fraud, which the Contractor has identified and submitted a referral of Fraud to LDH, MFCU, or other appropriate law enforcement agency, until approved by LDH in writing.	**2.20.6** Rights of Review and Recovery by Contractor and LDH **[…]** **2.20.6.8** Contact with a provider shall be prohibited in instances resulting from suspected **or confirmed** Fraud, which the Contractor has identified and submitted a referral of Fraud to LDH, MFCU, or other appropriate law enforcement agency, until approved by LDH in writing.	Revision is needed for the MCOs must use the Fraud Referral Form to refer any issue of fraud or abuse to LDH and MFCU, rather than deciding whether an issue is simply a notice. LDH is removing all references to fraud "notices" from the contracts.
75	**2.20.6** Rights of Review and Recovery by Contractor and LDH **[…]** **2.20.6.10** LDH or its agent shall have the right to audit, review and investigate providers and Enrollees within the Contractor's network via "complex" or "automated" review for a five (5) year period from the date of service of a Claim. LDH may recover from the Contractor, via a deduction from the Contractor's Capitation Payment, all of the following amounts assessed to a provider as a result of LDH's audit, whether the provider is excluded from the Medicaid program or not: • Monetary Penalties assessed in accordance with the SURS Rule (LAC 50:I.4161.A.18); • State-identified improper payments and overpayments; • Overpayments determined through statistical sampling (extrapolation); and • Investigation costs.	**2.20.6** Rights of Review and Recovery by Contractor and LDH **[…]** **2.20.6.10** LDH or its agent shall have the right to audit, review and investigate providers and Enrollees within the Contractor's network via "complex" or "automated" **review.** ~~review for a five (5) year period from the date of service of a Claim~~. LDH may recover from the Contractor, via a deduction from the Contractor's Capitation Payment **and the Contractor may initiate a payment withhold from the provider for** all of the following amounts assessed to a provider as a result of LDH's audit, whether the provider is excluded from the Medicaid program or not: • Monetary Penalties **and/or Sanctions** assessed in accordance with **the MAPIL's recovery provisions (La. R.S. 46:438.6(A), (B), (C), and (D)), and/or** the SURS Rule (LAC 50:I.4161.A.**18**) **and any successor statutes or regulations**; • State-identified improper payments and overpayments; • Overpayments determined through statistical sampling (extrapolation); and • Investigation costs.	This revision is necessary to include updating as 10 years is allowed under MAPIL (see La. R.S. 46:438.1) for false claims.

76	**2.20.6** Rights of Review and Recovery by Contractor and LDH **[…]** **2.20.6.11.1** These recovered funds shall be retained by the State.	**2.20.6** Rights of Review and Recovery by Contractor and LDH **[…]** **2.20.6.11.1** **The** ~~**These**~~ recovered funds shall be retained by the State.	This revision is necessary to clarify the current language, but not change the requirement.
77	**2.20.6** Rights of Review and Recovery by Contractor and LDH **[…]** **2.20.6.16** The Contractor and its Subcontractors shall enforce LDH directives regarding sanctions on its Network Providers and Enrollees, including, but not limited to, termination or exclusion from the network.	**2.20.6** Rights of Review and Recovery by Contractor and LDH **[…]** **2.20.6.16** The Contractor and its Subcontractors shall enforce LDH directives regarding sanctions on its Network Providers and Enrollees, including, but not limited to, **payment suspension,** termination or exclusion from the network.	The revision is needed to clarify that that payment suspension is among the sanction options for which a plan may receive a directive from LDH.
78	**2.20.6** Rights of Review and Recovery by Contractor and LDH **[…]** **[new provision]**	**2.20.6** Rights of Review and Recovery by Contractor and LDH **[…]** **2.20.6.20 Upon approval from LDH, the Contractor may extrapolate an overpayment amount. The approval process is specified in the MCO Manual.**	Provision is added to provide clarification that extrapolation may be used by and MCO and emphasizing that there is a documented process for doing so.
79	**2.20.7** Program Integrity Requirements **[…]** **2.20.7.1** Notify LDH upon contact by any investigative authorities conducting Fraud and Abuse investigations, except in situations where investigative authorities make it illegal to provide such notice. The Contractor, and where applicable any Subcontractors or Material Subcontractors, shall cooperate fully with the agencies that conduct investigations; full cooperation includes, but is not limited to, Timely exchange of information and strategies for addressing Fraud and Abuse, as well as allowing prompt direct access to information, free copies of documents, and other available information related to program violations, while maintaining the confidentiality of any investigation. The Contractor shall make knowledgeable employees available at no charge to support any	**2.20.7** Program Integrity Requirements **[…]** **2.20.7.1** Notify LDH upon contact by any investigative authorities conducting Fraud and Abuse investigations, except in situations where investigative authorities make it illegal to provide such notice. The Contractor, and where applicable any Subcontractors or Material Subcontractors, shall cooperate fully with the agencies that conduct investigations; full cooperation includes, but is not limited to, Timely exchange of information and strategies for addressing Fraud and Abuse, as well as allowing prompt direct access to information, free copies of documents, and other available information related to program violations, while maintaining the confidentiality of any investigation. The Contractor shall make knowledgeable employees **directly** available at no	Revision is necessary to specify that direct access to employees must be made available.

	investigation, court, or administrative proceeding;	charge to support any investigation, court, or administrative proceeding;	
80	**3.1 Contract Management** **[…]** **3.1.12.3** Automatic Assignment **[…]** **3.1.12.3.1** LDH may automatically assign all Enrollees at the start of the Contract and shall automatically assign Potential Enrollees who do not request Enrollment in a specified MCO at the time of application for the Louisiana Medicaid Program or through the help of the Enrollment Broker, or who cannot be enrolled into the requested MCO for reasons including, but not limited to, the requested MCO having reached its Capacity or as a result of LDH-initiated sanctions. Following the the initial Enrollment of Enrollees at the start of the Contract, Enrollees who fail to select a new MCO during their Enrollment period shall remain enrolled with their existing MCO. These Enrollees shall not be subject to the Automatic Assignment process. **[…]** **3.1.12.3.4** The Automatic Assignment methodology for all populations shall be based on the following hierarchy: **3.1.12.3.4.1** If the Potential Enrollee or Enrollee has a current DCFS segment, the Potential Enrollee or Enrollee shall follow the DCFS Automatic Assignment process. **3.1.12.3.4.2** The Enrollment Broker shall seek to preserve existing Provider-Beneficiary Relationships. If the Potential Enrollee or Enrollee has had a relationship in the previous twelve (12) months with a provider assigned to an MCO, the Potential Enrollee or Enrollee shall be assigned to that MCO. • If the provider is in multiple MCO networks, and if the Potential Enrollee or Enrollee has household members enrolled in an MCO in	**3.1 Contract Management** **[…]** **3.1.12.3** Automatic Assignment **[…]** **3.1.12.3.1** LDH may automatically assign all Enrollees at the start of the Contract and shall automatically assign Potential Enrollees who do not request Enrollment in a specified MCO at the time of application for the Louisiana Medicaid Program or through the help of the Enrollment Broker, or who cannot be enrolled into the requested MCO for reasons including, but not limited to, the requested MCO having reached its Capacity or as a result of LDH-initiated sanctions. Following the ~~the~~ initial Enrollment of Enrollees at the start of the Contract, Enrollees who fail to select a new MCO during their Enrollment period shall remain enrolled with their existing MCO. These Enrollees shall not be subject to the Automatic Assignment process. **[…]** **3.1.12.3.4** The Automatic Assignment methodology **will be determined by LDH and detailed in the MCO Manual.** ~~for all populations shall be based on the following hierarchy:~~ ~~**3.1.12.3.4.1** If the Potential Enrollee or Enrollee has a current DCFS segment, the Potential Enrollee or Enrollee shall follow the DCFS Automatic Assignment process.~~ ~~**3.1.12.3.4.2** The Enrollment Broker shall seek to preserve existing Provider-Beneficiary Relationships. If the Potential Enrollee or Enrollee has had a relationship in the previous twelve (12) months with a provider assigned to an MCO, the Potential Enrollee or Enrollee shall be assigned to that MCO.~~	This revision is necessary to remove this language from the contract and add it to the MCO Manual.

	which the provider participates, the Potential Enrollee or Enrollee will be assigned to that MCO. If multiple MCO linkages exist within the household, the Potential Enrollee or Enrollee shall be assigned to the MCO in which the provider participates of the mother or head of household, if applicable, or to the MCO in which the provider participates to which a household member was most recently assigned. • If there is no MCO relationship within the household, the Potential Enrollee or Enrollee shall be assigned to the MCO in which the provider participates via a round robin method. **3.1.12.3.4.3** If MCO assignment cannot be made based on existing Provider-Beneficiary Relationships, and if the Potential Enrollee or Enrollee has household members enrolled in an MCO, the Potential Enrollee or Enrollee shall be assigned to that MCO. If multiple MCO linkages exist within the household, the Potential Enrollee or Enrollee shall be assigned to the MCO of the mother or head of household, if applicable, or to the MCO to which a household member was most recently assigned. **3.1.12.3.4.4** If there is no previous provider relationship or household relationship, the Enrollment Broker shall use a round robin method to determine the MCO assignment. **3.1.12.3.4.5** In addition, the Contractor's quality measures may be factored into the algorithm for Automatic Assignment, at the discretion of LDH.	~~• If the provider is in multiple MCO networks, and if the Potential Enrollee or Enrollee has household members enrolled in an MCO in which the provider participates, the Potential Enrollee or Enrollee will be assigned to that MCO. If multiple MCO linkages exist within the household, the Potential Enrollee or Enrollee shall be assigned to the MCO in which the provider participates of the mother or head of household, if applicable, or to the MCO in which the provider participates to which a household member was most recently assigned.~~ ~~• If there is no MCO relationship within the household, the Potential Enrollee or Enrollee shall be assigned to the MCO in which the provider participates via a round robin method.~~ ~~**3.1.12.3.4.3** If MCO assignment cannot be made based on existing Provider-Beneficiary Relationships, and if the Potential Enrollee or Enrollee has household members enrolled in an MCO, the Potential Enrollee or Enrollee shall be assigned to that MCO. If multiple MCO linkages exist within the household, the Potential Enrollee or Enrollee shall be assigned to the MCO of the mother or head of household, if applicable, or to the MCO to which a household member was most recently assigned.~~ ~~**3.1.12.3.4.4** If there is no previous provider relationship or household relationship, the Enrollment Broker shall use a round robin method to determine the MCO assignment.~~ ~~**3.1.12.3.4.5** In addition, the Contractor's quality measures may be factored into the algorithm for Automatic Assignment, at the discretion of LDH.~~	
81	**4.4 Financial Incentives for MCO Performance** **[…]**	**4.4 Financial Incentives for MCO Performance** **[…]**	This revision is necessary to clarify what will be included in the withhold measures.

	4.4.1.1 LDH may withhold a portion of the Contractor's monthly Capitation Payments to incentivize quality, health outcomes, value-based payments, and health equity. The withhold amount will be equal to two percent (2%) of the monthly Capitation Payments for integrated physical and behavioral health for all Enrollees, exclusive of maternity Kick Payments, payments under the Managed Care Incentive Program, and the Full Medicaid Pricing (FMP) component of the monthly Capitation Payments. **4.4.1.2** Half of the total withhold amount (i.e., one percent (1.0%) of the monthly Capitation Payments) shall be considered the quality withhold and applied to incentivize quality and health outcomes for Enrollees. The remaining half of the total withhold amount (i.e., one percent (1.0%) of the monthly Capitation Payment as described in 4.4.1.1.) shall be divided and allocated in equal proportion to the Value Based Payment (i.e., one-half percent (0.5%) of the applicable monthly Capitation Payment) and Health Equity (i.e., one-half percent (0.5%) of the applicable monthly Capitation Payment) withholds, respectively. The Value-Based Payment (VBP) withhold is applied to incentivize the Contractor's use and expansion of VBP arrangements with providers. The Health Equity withhold is applied to incentivize the Contractor's health equity strategies.	**4.4.1.1** LDH may withhold a portion of the Contractor's monthly Capitation Payments to incentivize quality~~,~~ **and** health outcomes.~~, value-based payments, and health equity.~~ The withhold amount will be equal to ~~two~~ **three** percent (~~2~~**3**%) of the monthly Capitation Payments for integrated physical and behavioral health for all Enrollees, exclusive of maternity Kick Payments, payments under the Managed Care Incentive Program, and ~~the Full Medicaid Pricing (FMP) component of the monthly Capitation Payments~~ **directed payment arrangements.** ~~**4.4.1.2** Half of the total withhold amount (i.e., one percent (1.0%) of the monthly Capitation Payments) shall be considered the quality withhold and applied to incentivize quality and health outcomes for Enrollees. The remaining half of the total withhold amount (i.e., one percent (1.0%) of the monthly Capitation Payment as described in 4.4.1.1.) shall be divided and allocated in equal proportion to the Value Based Payment (i.e., one-half percent (0.5%) of the applicable monthly Capitation Payment) and Health Equity (i.e., one-half percent (0.5%) of the applicable monthly Capitation Payment) withholds, respectively. The Value-Based Payment (VBP) withhold is applied to incentivize the Contractor's use and expansion of VBP arrangements with providers. The Health Equity withhold is applied to incentivize the Contractor's health equity strategies.~~	
82	**4.4 Financial Incentives for MCO Performance** **[…]** **4.4.1.7** LDH will not withhold funds from the Contractor for MCO performance until January 2024**.** **4.4.1.8** LDH may, at its sole discretion, suspend the withhold for a specified period with written notification to the Contractor.	**4.4 Financial Incentives for MCO Performance** **[…]** ~~**4.4.1.7** LDH will not withhold funds from the Contractor for MCO performance until January 2024.~~ ~~**4.4.1.8** LDH may, at its sole discretion, suspend the withhold for a specified period with written notification to the Contractor.~~	This revision is necessary to clarify what will be included in the withhold measures.

83	**4.4 Financial Incentives for MCO Performance** **[…]** **4.4.3** Earning the VBP Withhold For each Measurement Year, the Contractor may earn back the applicable VBP withhold based on meeting the VBP reporting and performance requirements and targets for that Measurement Year as established by this Contract including as described in the *Value-Based Payment* section. **[…]** **4.4.3.2.1.2** If LDH determines that the mid-year report demonstrates VBP use by the Contractor that includes applicable performance measures in Attachment H, Quality Performance Measures, and is consistent with LDH specifications in this Contract, LDH will refund a portion of the VBP-related amounts withheld for the calendar year prior to the end of the calendar year. The VBP withhold amounts shall not be refunded for late submissions. […] **4.4.3.2.3** If LDH determines that the Contractor's use of recognized VBP models meets the following VBP targets in each specific calendar year as described below, LDH will refund any remaining amounts withheld for VBP. Recognized VBP arrangements exclude certain LAN APM category 2A and 2B models and VBP models that do not have a link to at least two of the applicable Contractor performance measures in Attachment H, Quality Performance Measures, as defined in the Value-Based Payment sections of this Contract. **4.4.3.2.4** Unless otherwise modified by LDH, the minimum VBP thresholds for each Measurement Year are as follows: **4.4.3.2.4.1** Calendar Year 2023 • Contractual arrangements linked to a VBP model that includes one (1) or	**4.4 Financial Incentives for MCO Performance** **[…]** **4.4.3** Earning the VBP Withhold ~~For each Measurement Year~~ **For Calendar Year 2025**, the Contractor may earn back the applicable VBP withhold based on meeting the VBP reporting and performance requirements and targets for that Measurement Year as established by this Contract including as described in the *Value-Based Payment* section. **[…]** ~~**4.4.3.2.1.2 If LDH determines that the mid-year report demonstrates VBP use by the Contractor that includes applicable performance measures in Attachment H, Quality Performance Measures, and is consistent with LDH specifications in this Contract, LDH will refund a portion of the VBP-related amounts withheld for the calendar year prior to the end of the calendar year. The VBP withhold amounts shall not be refunded for late submissions.**~~ […] ~~**4.4.3.2.3 If LDH determines that the Contractor's use of recognized VBP models meets the following VBP targets in each specific calendar year as described below, LDH will refund any remaining amounts withheld for VBP. Recognized VBP arrangements exclude certain LAN APM category 2A and 2B models and VBP models that do not have a link to at least two of the applicable Contractor performance measures in Attachment H, Quality Performance Measures, as defined in the Value-Based Payment sections of this Contract.**~~ ~~**4.4.3.2.4 Unless otherwise modified by LDH, the minimum VBP thresholds for each Measurement Year are as follows:**~~	This revision is necessary to clarify what will be included in the withhold measures.

	more of the HCP LAN categories identified by LDH account for at least forty percent (40%) of total provider payments in the Measurement Year and the Contractor's total provider incentive payments related to this Measurement Year exceed six (6) million, OR the Contractor's total provider incentive payments exceed twelve (12) million dollars. • The Contractor's VBP models must include at least one (1) new provider contract with a category 3A APM, category 3B APM or category 4 APM that is effective no later than December 2023. • The Contractor must submit an annual report demonstrating how its VBP models align with LDH Contractor incentive-based and other contractual performance measures and provide initial data-based assessments to determine the extent to which providers participated in specific VBP models may be performing differently on targeted quality measures than providers not participating in such VBP models. **4.4.3.2.4.2** Calendar Year 2024 • Contractual arrangements linked to a VBP model account for at least fifty percent (50%) of total provider payments in the Measurement Year and the Contractor's total provider incentive payments related to this Measurement Year exceed seven (7) million dollars, or the Contractor's total provider incentive payments exceed fourteen (14) million dollars. • The Contractor's VBP models must include at least one (1) new provider contract with a category 3A APM, and one (1) new provider contract with a category 3B APM or category 4 APM that is effective no later than December 2024. • The Contractor must submit an annual report demonstrating how its VBP models align with LDH Contractor incentive-based and other contractual performance measures. • The Contractor must analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will use the results of this data analysis to improve it VBP models and provider	~~**4.4.3.2.4.1 Calendar Year 2023**~~ ~~• Contractual arrangements linked to a VBP model that includes one (1) or more of the HCP LAN categories identified by LDH account for at least forty percent (40%) of total provider payments in the Measurement Year and the Contractor's total provider incentive payments related to this Measurement Year exceed six (6) million, OR the Contractor's total provider incentive payments exceed twelve (12) million dollars.~~ ~~• The Contractor's VBP models must include at least one (1) new provider contract with a category 3A APM, category 3B APM or category 4 APM that is effective no later than December 2023.~~ ~~• The Contractor must submit an annual report demonstrating how its VBP models align with LDH Contractor incentive-based and other contractual performance measures and provide initial data-based assessments to determine the extent to which providers participated in specific VBP models may be performing differently on targeted quality measures than providers not participating in such VBP models.~~ ~~**4.4.3.2.4.2 Calendar Year 2024**~~ ~~• Contractual arrangements linked to a VBP model account for at least fifty percent (50%) of total provider payments in the Measurement Year and the Contractor's total provider incentive payments related to this Measurement Year exceed seven (7) million dollars, or the Contractor's total provider incentive payments exceed fourteen (14) million dollars.~~ ~~• The Contractor's VBP models must include at least one (1) new provider contract with a category 3A APM, and one (1) new provider contract with a category 3B APM or category 4 APM that is effective no later than December 2024.~~ ~~• The Contractor must submit an annual report demonstrating how its VBP models align with LDH Contractor incentive-based and other contractual performance measures.~~	

	support for future calendar years. **4.4.3.2.4.3** Calendar Year 2025 and Future Calendar Years Contractual arrangements linked to a VBP model account for at least sixty percent (60%) of total provider payments, and the Contractor's total provider incentive payments exceed eight (8) million dollars, or the Contractor's total provider incentive payments exceed sixteen (16) million dollars. The Contractor's VBP models must include at least one (1) new provider contract with a category 3A APM, one (1) new provider contract with a category 3B APM, and one new provider contract with a category 4 APM that is effective no later than the end of the applicable calendar year. The Contractor must submit an annual report demonstrating how its VBP models align with LDH Contractor incentive-based and other contractual performance measures. The Contractor must analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will use the results of this data analysis to improve VBP models and provider support for future calendar years. LDH may refund to the Contractor some of the remaining amounts withheld for VBP if the Contractor partially meets the applicable VBP targets in 4.4.3.2.4and describes to LDH's satisfaction why the Contractor did not fully meet the VBP targets. LDH shall retain the amount of the VBP withhold not earned back by the Contractor.	~~• The Contractor must analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will use the results of this data analysis to improve it VBP models and provider support for future calendar years.~~ **4.4.3.2.4.3** Calendar Year 2025 and Future Calendar Years Contractual arrangements linked to a VBP model account for at least sixty percent (60%) of total provider payments, and the Contractor's total provider incentive payments exceed eight (8) million dollars, or the Contractor's total provider incentive payments exceed sixteen (16) million dollars. The Contractor's VBP models must include at least one (1) new provider contract with a category 3A APM, one (1) new provider contract with a category 3B APM, and one new provider contract with a category 4 APM that is effective no later than the end of the applicable calendar year. The Contractor must submit an annual report demonstrating how its VBP models align with LDH Contractor incentive-based and other contractual performance measures. The Contractor must analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will use the results of this data analysis to improve VBP models and provider support for future calendar years. **For Calendar Year 2025,** LDH may refund to the Contractor some of the remaining amounts withheld for VBP if the Contractor partially meets the applicable VBP targets in 4.4.3.2.4 and describes to LDH's satisfaction why	

		the Contractor did not fully meet the VBP targets. **For Calendar Year 2025,** LDH shall retain the amount of the VBP withhold not earned back by the Contractor. **[subsequent items will be renumbered]**	
84	**4.4.4** Earning Health Equity Withhold For each Measurement Year, the Contractor may earn back the applicable Health Equity withhold based on its reporting and performance relative to Health Equity requirements for that Measurement Year as established by this Contract and LDH as described in the Health Equity section. **4.4.4.1** The Contractor may earn back the health equity withhold amount for the development and the submission of health equity deliverables specified by LDH in the Health Equity section:	~~**4.4.4** Earning Health Equity Withhold~~ ~~For each Measurement Year, the Contractor may earn back the applicable Health Equity withhold based on its reporting and performance relative to Health Equity requirements for that Measurement Year as established by this Contract and LDH as described in the Health Equity section.~~ ~~**4.4.4.1** The Contractor may earn back the health equity withhold amount for the development and the submission of health equity deliverables specified by LDH in the Health Equity section:~~ **[subsequent items will be renumbered]**	This revision is necessary to ensure reporting is maintained and submitted as required.
85	**4.4.5** Other Requirements Related to Quality and VBP Withholds **4.4.5.1** If, in the final determination of Contractor performance relative to Quality and Health Outcomes, VBP and Health Equity incentives, the Contractor's unearned withhold amount exceeds its withhold balance held in escrow by LDH, the Contractor is responsible for remitting payment for the balance to LDH within thirty (30) Calendar Days following notification to the Contractor by LDH unless otherwise authorized in writing by LDH. LDH, at its discretion, reserves the right	**4.4.5** Other Requirements Related to Quality ~~and VBP Withholds~~ **4.4.5.1** If, in the final determination of Contractor performance relative to Quality and Health Outcomes, ~~VBP and Health Equity incentives,~~ the Contractor's unearned withhold amount exceeds its withhold balance held in escrow by LDH, the Contractor is responsible for remitting payment for the balance to LDH within thirty (30) Calendar Days following notification to the Contractor 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	This revision is necessary to clarify what will be included in the withhold measures.

	to collect amounts due by withholding and applying all balances due to LDH to future payments.	payments.	
86	**4.18** Reimbursement for COVID-19 Vaccine Administration **4.18.1** LDH will pay the Contractor, on a quarterly, non-risk basis, for the costs of COVID-19 vaccine administration to Contractor Enrollees in accordance with the Louisiana Medicaid COVID-19 Vaccine and Treatment Fee Schedule. This payment shall be separate from the monthly Capitation Payments and be based upon Encounter Data provided by the Contractor to LDH that have been accepted and have cleared all systems edits in the MMIS. This non-risk arrangement is subject to Federal requirements for payments under non-risk managed care contracts at 42 CFR § 447.362. **4.18.2** The Contractor shall submit all COVID-19 vaccine administration Encounters in accordance with the terms and conditions of this Contract. **4.18.3** The Contractor shall report expenditures for COVID-19 vaccine administration on a date of service basis. **4.18.4** The Contractor shall pay COVID-19 vaccine administration Claims when performed and coded appropriately and according to the FFS fee schedule. **4.19** Reimbursement for COVID-19 Vaccine Incentive Distribution **4.19.1** LDH will pay the Contractor, on a monthly, non-risk basis, for the costs of COVID-19 vaccine incentive distribution to its Enrollees in accordance with the Louisiana Medicaid COVID-19 "Shot Per 100,000" COVID vaccine administration member incentive program. The Enrollee incentive amount paid shall be determined by LDH. The Contractor is entitled to a nine percent (9%) administration fee in addition to the amount of the incentive distributed through the "Shot Per 100,000" program. All payments associated with this program shall be paid on an administrative cost basis, separately from the monthly Capitation Payments. The Contractor will identify eligible Enrollees by leveraging LDH's existing data extraction processes and weekly COVID vaccine administration reports and by utilizing the Contractor's internal	~~**4.18** Reimbursement for COVID-19 Vaccine Administration~~ ~~**4.18.1** LDH will pay the Contractor, on a quarterly, non-risk basis, for the costs of COVID-19 vaccine administration to Contractor Enrollees in accordance with the Louisiana Medicaid COVID-19 Vaccine and Treatment Fee Schedule. This payment shall be separate from the monthly Capitation Payments and be based upon Encounter Data provided by the Contractor to LDH that have been accepted and have cleared all systems edits in the MMIS. This non-risk arrangement is subject to Federal requirements for payments under non-risk managed care contracts at 42 CFR § 447.362.~~ ~~**4.18.2** The Contractor shall submit all COVID-19 vaccine administration Encounters in accordance with the terms and conditions of this Contract.~~ ~~**4.18.3** The Contractor shall report expenditures for COVID-19 vaccine administration on a date of service basis.~~ ~~**4.18.4** The Contractor shall pay COVID-19 vaccine administration Claims when performed and coded appropriately and according to the FFS fee schedule.~~ ~~**4.19** Reimbursement for COVID-19 Vaccine Incentive Distribution~~ ~~**4.19.1** LDH will pay the Contractor, on a monthly, non-risk basis, for the costs of COVID-19 vaccine incentive distribution to its Enrollees in accordance with the Louisiana Medicaid COVID-19 "Shot Per 100,000" COVID vaccine administration member incentive program. The Enrollee incentive amount paid shall be determined by LDH. The Contractor is entitled to a nine percent (9%) administration fee in addition to the amount of the incentive distributed through the "Shot Per 100,000" program. All payments associated with this program shall be paid on an administrative cost basis, separately from the monthly Capitation Payments. The Contractor will identify eligible Enrollees by leveraging~~	This revision is necessary to remove this requirement as it is outdated by new regulations.

	resources. The Contractor will use various data sources and internal databases to confirm Enrollee eligibility for the incentive. **4.19.2** The Contractor shall submit all data related to the **COVID-19 vaccine incentive in accordance with the terms and conditions of this Contract and the reporting template developed for the "Shot Per 100,000" program.** **4.19.3** The Contractor shall report expenditures for COVID-19 vaccine incentives on a date of service basis. **4.19.4** The Contractor shall distribute the COVID-19 vaccine incentive to Enrollees within five (5) Business Days of the Contractor validating the Enrollee's eligibility to receive the COVID-19 vaccine incentive.	~~LDH's existing data extraction processes and weekly COVID vaccine administration reports and by utilizing the Contractor's internal resources. The Contractor will use various data sources and internal databases to confirm Enrollee eligibility for the incentive.~~ ~~**4.19.2** The Contractor shall submit all data related to the COVID-19 vaccine incentive in accordance with the terms and conditions of this Contract and the reporting template developed for the "Shot Per 100,000" program.~~ ~~**4.19.3** The Contractor shall report expenditures for COVID-19 vaccine incentives on a date of service basis.~~ ~~**4.19.4** The Contractor shall distribute the COVID-19 vaccine incentive to Enrollees within five (5) Business Days of the Contractor validating the Enrollee's eligibility to receive the COVID-19 vaccine incentive.~~	

LOUISIANA MEDICAID
MANAGED CARE ORGANIZATION

Attachment A: Model Contract

LOUISIANA DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES FINANCING

TABLE OF CONTENTS

LIST OF CONTRACT ATTACHMENTS

Attachment A: Model Contract
Attachment B: MCO Covered Services
Attachment C: In Lieu of Services
Attachment D: Actuarial Rate Certification Letter* *(to be added via an amendment)*
Attachment E: APM Reporting Template
Attachment F: Provider Network Standards
Attachment G: Table of Monetary Penalties
Attachment H: Quality Performance Measures
Attachment I: OIG Addendum

*The Contractor shall receive this attachment immediately upon its completion by LDH's contracted actuary.

LIST OF MANUALS AND GUIDES

Batch Pharmacy Encounter System Companion Guide
Chisholm Compliance Guide
DOJ Agreement Compliance Guide
Financial Reporting Guide
Justice-Involved Pre-Release Enrollment Program Manual
Louisiana Crisis Response System Companion Guide

Marketing and Member Education Companion Guide
MCO Manual
MCO Quality Companion Guide
MCO System Companion Guide
Benefit Enrollment and Maintenance (834) Louisiana Medicaid EDI Transaction Set Companion Guide
State Fair Hearing Companion Guide

PART 1: GLOSSARY AND ACRONYMS

Glossary

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

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

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

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

Abuse – Practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Louisiana Medicaid Program, or in payment for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

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

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

Adjudicate – To deny or pay a Claim.

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

Adverse Benefit Determination – Any of the following:

- The denial or limited authorization of a requested service, including, but not limited to, determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a Timely manner, as defined by the State.
- The failure of the Contractor to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals.
- The denial of an Enrollee's request to dispute a financial liability, including Cost Sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

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

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

1) Owns or holds more than a five percent (5%) interest in the MCO (either directly, or through one (1) or more intermediaries);
2) Is an entity in which the MCO owns or holds more than a five percent (5%) interest, either directly or through one (1) or more intermediaries;
3) Is a parent entity or subsidiary entity of the MCO regardless of the organizational structure of the entity;
4) Has a common parent with the MCO, either directly or through one (1) or more intermediaries;
5) Directly, or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, the MCO; or
6) Would be considered an affiliate by any Securities and Exchange Commission (SEC) or Internal Revenue Service (IRS) regulation, Federal Acquisition Regulations (FAR), or by another applicable regulatory body.

Alternative Payment Methodology – A method of reimbursing a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) outside of the Prospective Payment System (PPS). The methodology must be agreed to by the State and the FQHC or RHC, result in a payment to the FQHC or RHC that is at least equal to the amount to which it is entitled under the PPS, and be described in the State Plan.

Alternative Payment Model (APM) – A payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

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

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

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

Appeal* – A request for a review of an Adverse Benefit Determination.

Appeal Procedure – A formal process whereby an Enrollee can contest an adverse determination rendered by the Contractor, which results in the denial, reduction, suspension, termination or delay of health care benefits/services. The Appeal Procedure shall be governed by Federal and State laws, regulations, rules, policies, procedures, and manuals, and all applicable court orders and consent decrees.

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

Authorized Representative – An individual or organization designated by a Beneficiary, or authorized under State law, including, but not limited to, a court order establishing legal guardianship or a power of attorney, to act responsibly on their behalf, in accordance with 42 CFR §435.923.

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

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

Beneficiary – An individual who has been determined eligible, pursuant to Federal and State law, to receive medical care, goods, or services under the Louisiana Medicaid Program.

Bureau of Health Services Financing (BHSF) – The agency within the Louisiana Department of Health that is responsible for administration and oversight of the Louisiana Medicaid Program.

Business Continuity Plan (BCP) – A plan that provides for a quick and smooth restoration of all Contractor functions after a disruptive event. BCP includes business impact analysis, development, testing, awareness, training, and maintenance. This is a day-to-day plan.

Business Day –Monday, Tuesday, Wednesday, Thursday, and Friday, excluding State-designated holidays. In computing a period of time prescribed in Business Days, the date of the triggering act or event is not to be included. The last day of the period is to be included, unless it is a Saturday, a Sunday, or a State-designated holiday, in which event the period shall run until the end of the next day that falls on a Business Day.

Business Hours – 8:00 a.m. – 5:00 p.m. Central Time on Business Days.

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

Calendar Days – All seven (7) days of the week. Unless otherwise specified, the term "day" in the Contract refers to Calendar Days. In computing a period of time prescribed in Calendar Days, the date of the triggering act or event is not to be included, and the last day of the period is to be included.

Can – A term that denotes an allowable activity, but not a mandatory requirement.

Capacity – The maximum number of Enrollees that may be enrolled with the Contractor as determined by LDH in its sole discretion.

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

Capitation Rate – Rates that are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the Contract and for the operation of the Contractor for the time period and the population covered under the terms of the Contract and are developed in accordance with the requirements of 42 CFR §438.4(b).

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

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Care Management – An overall approach to managing Enrollees' care needs and preferences and encompasses a set of activities intended to improve patient care and reduce the need for medical services by enhancing coordination of care, eliminating duplication, and helping patients and caregivers more effectively manage health conditions. Care Management includes, but is not limited to, Care Coordination, Case Management, and Utilization Management.

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

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

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Centers for Medicare and Medicaid Services (CMS) – The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act.

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

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

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

Claim – (1) A bill for services, (2) a line item of service, or (3) all services for one Enrollee within a bill.

Clean Claim – A Claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a Claim with errors originating in the State's Claims system. It does not include a Claim from a provider who is under investigation for Fraud or Abuse, or a Claim under review for medical necessity.

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

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

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

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

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

Contract – The written agreement between LDH and the Contractor, which is comprised of the terms and conditions set forth in the LDH Standard Contract Form – CF-1, any attachments and/or exhibits incorporated therein, and any amendments thereof; the RFP and any addenda issued thereto; and the Contractor's proposal, and any appendices, attachments, and exhibits thereto or incorporated therein by reference.

Contract Execution Date – The date upon which the Office of State Procurement approves the Contract.

Contractor – The entity that enters into this Contract with LDH for the provision of services described herein.

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

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

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

Co-payment* – A fixed amount per medical service for which the Enrollee is responsible. This is a type of cost sharing arrangement and must be in accordance with 42 CFR §438.108 and Section 5006 of the American Recovery and Reinvestment Act of 2009 (ARRA) for Native American Enrollees.

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

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

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

Cost Sharing – Any co-payment, coinsurance, deductible, or other similar charge as per 42 CFR §447.51.

Covered Drug List – A list maintained by the Contractor giving details of generic and name brand

medications payable by the Contractor. The Covered Drug List shall include all outpatient drugs for which the manufacturer has entered into the Federal rebate agreement with CMS that meets the standards in Section 1927 of the Social Security Act.

Covered Entity - Health care clearinghouses and those health care providers who transmit any health information in electronic form in connection with a standard transaction.

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

Cultural Competency – A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Enrollees. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse Enrollee needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

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

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

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

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

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

- Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments;
- Is manifested before the person reaches age twenty-two (22);
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three (3) or more of the following areas of major life activity:
  - Self-care;
  - Receptive and expressive language;
  - Learning;
  - Mobility;
  - Self-direction;

- Capacity for independent living; and
- Economic self-sufficiency;

- Is not attributable solely to mental illness; and
- Reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

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

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

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

Dispensing Fee – The professional fee which: (1) is incurred at the point of sale (POS) or service and pays for the costs in excess of the ingredient cost of a covered outpatient drug each time a covered outpatient drug is dispensed; (2) includes only pharmacy costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to an Enrollee. Pharmacy costs include, but are not limited to, reasonable costs associated with a pharmacist's time in checking the computer for information about an Enrollee's coverage, performing drug utilization review and preferred drug list review activities, measurement or mixing of the covered outpatient drug, filing the container, Enrollee counseling, physically providing the completed prescription to the Enrollee, delivery, special packaging, and overhead associated with maintaining the facility and equipment necessary to operate the pharmacy; and (3) does not include administrative costs incurred by the State in the operation of the covered outpatient drug benefit including system costs for interfacing with pharmacies.

Disproportionate Share Hospitals - Hospitals that serve a disproportionate share of low-income patients.

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

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

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

Durable Medical Equipment*, Prosthetics, Orthotics and certain Supplies (DMEPOS) – DME is inclusive of equipment which 1) can withstand repeated use, 2) is primarily and customarily used to serve a medical purpose, 3) generally is not useful to a person in the absence of illness or injury, and 4) is appropriate for

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

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use in the home. POS is inclusive of prosthetics, orthotics and certain supplies. Certain supplies are those medical supplies that are of an expendable nature, such as catheters and diapers.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – All medically necessary Section 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT-eligible Beneficiaries ages birth through twenty (20), in accordance with 42 U.S.C. §1396d(r). This includes but is not limited to, conditions which are discovered through EPSDT Well Child screening services, whether or not such services are covered under the State Plan. [42 U.S.C. §1396d(r)(5) and the CMS State Medicaid Manual.]

EarlySteps – Program that provides services to families with infants and toddlers aged birth through thirty-six (36) months who have a medical condition likely to result in a developmental delay, or who have developmental delays. Children with delays in cognitive, motor, vision, hearing, communication, social-emotional or adaptive development may be eligible for services. These services are provided in the child's natural environment, such as the child's home, childcare, or any other community setting typical for children aged birth through thirty-six (36) months.

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

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

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

Emergency Medical Transportation* – Transportation provided for an Emergency Medical Condition.

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

Emergency Services* – Covered inpatient and outpatient services that are as follows: (a) furnished by a provider that is qualified to furnish these services under Title 42 of the Code of Federal Regulations and Title XIX of the Social Security Act; and (b) needed to evaluate or stabilize an Emergency Medical Condition.

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

Encounter Data – Includes: (i) All data captured during the course of a single health care encounter that

specify the diagnoses, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the Enrollee receiving services during the encounter; (ii) the identification of the Enrollee receiving and the provider(s) delivering the health care services during the single encounter; and (iii) a unique, unduplicated, identifier for the single encounter.

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

Enrollee – Beneficiary who is currently enrolled in an MCO, either by choice or Automatic Assignment by the Enrollment Broker.

Enrollees with Special Health Care Needs (SHCN) – Special Health Care Needs Populations are individuals, across the lifespan, who have chronic physical, developmental, behavioral, or emotional conditions that significantly impact their health and daily functioning. These individuals require health and related services of a type or amount beyond what is typically needed by most people. They often experience:

- Complex care needs involving multiple providers, agencies, or systems.
- Fragmented or poorly integrated care, leading to gaps in treatment and coordination.
- Frequent transitions between care settings (e.g., hospital to home, pediatric to adult care), which can disrupt continuity and quality of care.
- Cognitive, behavioral, social, or functional limitations that hinder self-management and independence.
- Limited or absent support from family caregivers, increasing reliance on formal systems of care.
- Barriers related to social determinants of health, such as poverty, housing instability, transportation challenges, language barriers, and limited health literacy, which impede access to and navigation of health services.

These populations require person-centered, coordinated, and equitable care models that address both clinical and non-clinical needs, promote health equity, and support long-term well-being.

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

- ~~have complex needs such as multiple chronic conditions, co-morbidities, and co-existing functional impairments;~~
- ~~are at high risk for admission/readmission to a hospital within the next six (6) months;~~
- ~~are at high risk of institutionalization;~~

~~have been diagnosed with a Serious Emotional Disturbance, a Severe and Persistent Mental Illness, or a Substance Use Disorder, or otherwise have significant behavioral health needs, including those Enrollees presenting to the hospital or emergency department with a suicide attempt or non-fatal opioid, stimulants, and sedative/hypnotic drug overdose reason;~~

- ~~are homeless as defined in Section 330(h)(5)(A) of the Public Health Service Act and codified by the US Department of Health and Human Services in 42 U.S.C. §254(b);~~
- ~~are women with high-risk pregnancies (i.e., pregnancies that have one or more risk factors) or who have had an adverse pregnancy outcome during the pregnancy, including preterm birth of less than thirty-seven (37) weeks;~~
- ~~have been recently incarcerated and are transitioning out of custody;~~
- ~~are at high risk of inpatient admission or emergency department visits, including certain Enrollees transitioning care across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting;~~
- ~~are members of the DOJ Agreement Target Population;~~
- ~~are enrolled under the Act 421 Children's Medicaid Option; or~~
- ~~receive care from other State agency programs, including, but not limited to, programs through OJJ, DCFS, or OPH.~~

Enrollment – The process conducted by the Enrollment Broker by which an eligible Beneficiary becomes enrolled with an MCO.

Enrollment Broker – The State's designated contractor that performs functions related to choice counseling, Enrollment, and Disenrollment of Potential Enrollees and Enrollees into an MCO.

Enrollment Period – A period of time within which an Enrollee may change MCOs without cause.

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

Excluded Populations – Beneficiaries who are excluded from the Managed Care Program.

Excluded Services* – Those services that Enrollees may obtain under the State Plan or applicable Waivers and for which the Contractor is not financially responsible.

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

Experimental Procedure/Service – A procedure or service that requires additional research to determine safety, effectiveness, and benefit compared to standard practices and characteristics of patients most likely to benefit. The available clinical scientific data may be limited or inconclusive. The term applies only to the determination of eligibility for coverage or payment.

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

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

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

Federal Financial Participation (FFP) – The Federal share of a State's expenditures under the Medicaid program. Also known as Federal match.

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

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

Fee-for-Service (FFS) Rate –The reimbursement rate published on www.lamedicaid.com or on the weekly procedure file sent to the Contractor by the FI, or its equivalent, whichever is most current on the date of service. Also referred to as the "Medicaid rate".

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

Fiscal Intermediary (FI) – LDH's contractor responsible in the current delivery model for an array of support services including MMIS development and support, Claims processing, pharmacy support services, provider support services, financial and accounting systems, Prior Authorization and utilization management, Fraud and Abuse systems, and decision support.

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

Formulary – A list maintained by the Contractor giving details of medications payable by the Contractor.

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, including but not limited to, the Medical Assistance Programs Intergrity Law, La. R.S 46:437.1 et seq and the Federal False Claims Act 31 U.S.C 3729 et seq. Fraud may include, but is not limited to, deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or Claiming payment for services which were never delivered or received.

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Full Medicaid Pricing (FMP) - A program to ensure consistent pricing in the Managed Care Program to maintain and increase access to certain services, as specified in the Contract, for enrolled Medicaid populations.

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

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

Grievance System – The manner in which Enrollee Grievances, Appeals, and access to the State's fair hearing system are managed.

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

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

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

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

Health Equity – Achieved when every person in a community has the opportunity to reach their full health potential and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."

Health Equity Plan - The Contractor's strategic initiatives and approaches to activate practices, protocols, and resources that equitably and effectively support the wellness and well-being of all the people, populations, and communities LDH serves, consistent with the LDH Health Equity Plan (see https://ldh.la.gov/assets/cphe/Equity_Framework.pdf).

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

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

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

HIPAA Privacy Rule - 45 CFRCFR Part 160 and Subparts A and E of Part 164.

HIPAA Security Rule - 45 CFR Part 160 and Subparts A and C of Part 164.

Home and Community Based Services (HCBS) Waiver – Under 42 U.S.C. §1396n(c), states may request waiver of the requirements relating to statewide comparability of services, and community income and resource rules for the medically needy in order to develop Medicaid-financed community-based treatment alternatives. Non-Medicaid Covered Services that may be offered include case management, homemaker/home health aide services, personal care services, adult day health, habilitation, and respite care.

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

Homeless – As defined in 42 U.S.C. §254b, means, an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing. A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or any other unstable or non-permanent situation. A person may be considered to be homeless if that person is "doubled up," a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. In addition, previously homeless individuals who are to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. A recognition of the instability of an individual's living arrangements is critical to the definition of homelessness (HRSA/Bureau of Primary Health Care, Program Assistance Letter 99-12).

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

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

Hospitalization* – Admission to a hospital for treatment.

ICD-10-CM codes – International Classification of Diseases, 10th Revision, Clinical Modification codes represent a uniform, international classification system of coding disease and injury diagnoses. This coding system arranges diseases and injuries into code categories according to established criteria. MCOs shall transition to newer versions as they become effective.

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

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

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

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

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

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

Information Systems (IS) – A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.

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

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

Deleted: , formerly known as mental retardation,

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

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

Intermediate Sanctions – Those actions authorized by 42 CFR Part 438, Subpart I for certain actions or omissions by the Contractor.

Investigational Procedure/Service – See Experimental Procedure/Service.

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

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

Legend Drugs – Drugs which bear the Federal legend: "Caution: Federal law prohibits dispensing without a prescription."

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

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

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

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

Louisiana Children's Health Insurance Program (LaCHIP) State Plan – An agreement between the State and CMS that describes how LaCHIP is administered and sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed, and the administrative activities

that are underway in the State.

Louisiana Crisis Hub (LCH) - A statewide crisis line that acts as the primary access point for Louisiana Crisis Response System services through a process of triage, referral and dispatch. The crisis line is available twenty-four (24) hours a day, seven (7) days a week, collaborates with MCOs and crisis providers to track data and ensure coordination of supports.

Louisiana's Health Insurance Premium Payment Program (LaHIPP) – State Medicaid program that pays for some or all of the health insurance premiums for an employee and their family if they have insurance available through their job or a plan purchased on the private market.

Louisiana Medicaid Program – As used in this Contract, includes the State's Medicaid program and LaCHIP.

Louisiana Medicaid State Plan – An agreement between the State and CMS that describes how the State's Medicaid program is administered and sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed, and the administrative activities that are underway in the State.

Managed Care Organization (MCO) – A private entity that contracts with LDH to provide covered healthcare services to Enrollees in exchange for a monthly capitated amount per Enrollee. The entity is regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency, pursuant to La. R.S. 22:1016, but shall, solely with respect to its products and services offered pursuant to the Managed Care Program, be regulated by the LDH.

Managed Care Program – A managed care delivery system wherein covered health care services are provided through MCOs.

Mandatory MCO Population – The groups of Beneficiaries who are required to enroll in the Managed Care Program for physical health, behavioral health, and/or transportation services.

Marketing – Any communication from the Contractor to and Enrollee or Potential Enrollee that can reasonably be interpreted as intended to influence the Enrollee's choice of MCO.

Marketing Materials – Information produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to Potential Enrollees or Enrollees**.**

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

Material Changes – Changes affecting the delivery of care or services provided under this Contract. Material changes include, but are not limited to, changes in composition of the provider network, Subcontractor, or Subcontractor's network; the Contractor's complaint and grievance procedures; health care delivery systems; services; changes to proposed value-added benefits or services; Enrollment of a new population; procedures for obtaining access to or approval for health care services; any and all

policies and procedures that require LDH approval prior to implementation; and the Contractor's capacity to meet minimum Enrollment levels. LDH shall make the final determination as to whether a change is material.

Material Subcontract – Any contract or agreement by which the Contractor procures, re-procures, or proposes to subcontract with, for the provision of all, or part, of any program area or function that directly relates to the delivery or payment of MCO Covered Services including, but not limited to, behavioral health, Claims processing, care management, utilization management, transportation, or pharmacy benefits, including specialty pharmacy providers. This shall include master service agreements or memorandums of understanding between the Contractor and its parent company, and any amendments thereto.

Material Subcontractor – Any entity with a Material Subcontract with the Contractor. For the purposes of this Contract, Material Subcontractors do not include providers in the Contractor's provider network. Material Subcontractors may include, without limitation, Affiliates, subsidiaries, and affiliated and unaffiliated third parties.

May – A Denotes an allowable activity, but not a mandatory requirement.

MCO Covered Services – Those Medicaid Covered Services that are required to be provided by the Contractor to Enrollees as specified in Attachment B, *MCO Covered Services*, of the Contract.

MCO Manual – A compilation of policies, instructions, and guidelines established by LDH for the administration of the Managed Care Program.

Measurable – Applies to the Contractor objective and means the ability to determine definitively whether or not the objective has been met, or whether progress has been made toward a positive outcome.

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

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

Medicaid Covered Services – Those health care benefits and services to which an eligible Beneficiary is entitled under the State Plan.

Medicaid ID Number – The 13-digit identifying number assigned to a Beneficiary by the State.

Medicaid Management Information System (MMIS) – Mechanized Claims processing and information retrieval system used to process Claims for FFS and Encounters for the Managed Care Program.

Medicaid Provider* – Any service provider contracted with an MCO and/or enrolled in the Louisiana Medicaid Program.

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

Medical Loss Ratio (MLR) – Measure of the percentage of adjusted premium revenues that the Contractor spends on incurred Claims, health care quality improvement activities, and Fraud prevention activities, versus administrative costs and profit, as calculated in accordance with 42 CFR §438.8.

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 Services whether provided by the Contractor, its Subcontractor, or any out-of-Network Providers. The records may be electronic, paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 CFR §456.111 and §456.211.

Medically Necessary Services* – Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the Beneficiary. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the Beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Louisiana Medicaid Program. Services that are experimental, non-Food and Drug Administration (FDA) approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

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

Member Materials – All written materials produced or authorized by the Contractor and distributed to Enrollees or Potential Enrollees containing information concerning the Contractor, including, but not limited to, MCO Member ID Cards, member handbooks, provider directories, and Marketing Materials.

Member Month – A month of coverage for an Enrollee.

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

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

Must – Denotes a mandatory requirement.

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

Network* – The collective group of providers who have entered into Provider Agreements with the Contractor for the delivery of MCO Covered Services. This includes, but is not limited to physical, behavioral, pharmacy, and Ancillary Service providers. Also referred to as Provider Network.

Network Adequacy – Refers to the network of health care providers for the Contractor 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-to-patient ratios; geographic accessibility and travel distance; appointment access and timeliness; and hours of provider operations. Network Adequacy will be assessed on the Contractor's Network Providers excluding single case agreements unless otherwise approved by LDH.

Network Provider or Provider* – An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors that has a signed Network Provider Agreement with the Contractor for the delivery of MCO Covered Services to the Contractor's Enrollees.

Network Provider Agreement – A contract between the Contractor and a Network Provider for the delivery of MCO Covered Services to Enrollees, including any In Lieu of Services offered by the Contractor.

New Entrant – An MCO under this Contract that was not contracted with LDH as an MCO during the period of January 1, 2020 through December 31, 2022.

Newborn – A live infant born to an Enrollee.

Non-Emergency Ambulance Transportation (NEAT) – a ride provided to an Enrollee with no other transportation resources that is not ambulatory and must travel via ambulance. NEAT does not include transportation provided on an emergency basis.

Non-Emergency Medical Transportation (NEMT) – A ride, or reimbursement for a ride, provided so that an Enrollee with no other transportation resources can receive services from an entity providing Medicaid Covered Services. NEMT does not include transportation provided on an emergency basis.

Non-Emergency Services –Services provided to an Enrollee who has signs, symptoms, or both, of a non-Emergency Medical Condition

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

Nurse Practitioner (NP) – An advanced practice registered nurse educated in a specified area of care and certified according to the requirements of a nationally recognized accrediting agency such as the American Nurses Association's American Nurses Credentialing Center, National Certification Corporation for the

Obstetric, Gynecologic and Neonatal Nursing Specialties, or the National Certification Board of Pediatric Nurse Practitioners and Nurses, or as approved by the Louisiana State Board of Nursing and who is authorized to provide primary, acute, or chronic care, as an advanced nurse practitioner acting within his/her scope of practice to individuals, families, and other groups in a variety of settings including, but not limited to, homes, institutions, offices, industry, schools, and other community agencies.

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

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

Operational Start Date – The first date on which the Contractor is responsible for providing MCO Covered Services to their Enrollees and is responsible for compliance with all aspects of the Contract. This date is at the discretion of LDH, but is anticipated to be January 1, 2023. The Operational Start Date may be delayed by LDH for the Contractor depending on the results of the Readiness Review.

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

Opt-In Case Management Program – Enrollee must give consent and "opt-in" to participate in this type of case management program.

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Outlier – Additional payment that is made for catastrophic costs associated with services provided to 1) children under the age of six (6) who received inpatient services in a Disproportionate Share Hospital setting, and 2) infants who have not attained the age of one year who received inpatient services in any Acute Care setting.

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

Part 2 Program - as defined in 42 CFR §2.11.

Pass-though Visits - The allowance of a certain number of visits to be provided without authorization.

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

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

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

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

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

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

Permanent Supportive Housing (PSH) Program – A cross-disability program that provides rental subsidies for affordable housing units statewide to low income Enrollees with substantial, long-term disabilities. PSH services are reimbursed under several HCBS programs, and under Specialized Behavioral Health Services where it is billed as a component of Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), and Assertive Community Treatment (ACT). To be eligible for PSH, Enrollees must meet PSH Program eligibility criteria and medical necessity criteria for services. Overall management of the PSH Program is centralized within LDH and final approval for Enrollees to participate in the PSH is made by the LDH PSH Program staff.

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

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

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

Physician Services* – The services provided by an individual licensed under State law to practice medicine or osteopathy. It does not include services that are offered by physicians while an Enrollee is admitted in a hospital, and charges that are included in the hospital Claim.

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

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

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

Post-Stabilization Care Services – Medicaid Covered Services, related to an Emergency Medical Condition, that are provided after an Enrollee is stabilized in order to maintain the stabilized condition or, under the circumstances described in 42 CFR §438.114, to improve or resolve the Enrollee's condition.

Potential Enrollee – A Beneficiary who is subject to mandatory Enrollment or may voluntarily elect to enroll in the Managed Care Program, but is not yet enrolled in an MCO.

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

Preferred Drug List (PDL) – A list maintained by LDH indicating which drugs are covered without the need for Prior Authorization, with the exception that some preferred drugs require Prior Authorization to validate clinical criteria.

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

Pre-Payment Review – Any action by an MCO requiring a Network Provider or an Out-of-Network Provider to provide medical record documentation in conjunction with or after the submission of a Claim for payment for medical services rendered, but before the Claim has been Adjudicated by the MCO.

Prescription Drug* – A drug that can be obtained only by means of a prescription from a qualified provider.

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

Preventive Care – Preventive health care services include immunizations, screenings for common chronic and infectious diseases and cancers, clinical and behavioral interventions to manage chronic disease and reduce associated risks, and counseling to support healthy living and self-management of chronic disease.

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

Primary Care Provider (PCP) Automatic Assignment – The process utilized by the Contractor to assign Enrollees to a PCP using predetermined algorithms.

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

maintenance, and health promotion either through direct service to the Enrollee when possible or through appropriate referral to specialists and/or ancillary providers.

Prime Rate – The bank prime loan rate reported by the Federal Reserve on its H.15 statistical release: *Selected Interest Rates.*

Prior Authorization – The process of determining medical necessity for specific services before they are rendered.

Prospective Payment System (PPS) – A method of payment in which the Medicaid payment is made based on a predetermined, fixed amount.

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

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

Provider Agreement – See Network Provider Agreement.

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

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

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

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

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

Quality – As it pertains to external quality review, means the degree to which the Contractor increases the likelihood of desired health outcomes of its Enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Assessment and Performance Improvement (QAPI) Plan – A written plan detailing the

Contractor's quality management and committee structure, performance measures, monitoring and evaluation process, and improvement activities measures that rely upon quality monitoring implemented to improve health care outcomes for Enrollees.

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

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

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

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

Recognized Peer Support Specialist (RPSS) - Refers to individuals with personal lived experience with recovery from behavioral health conditions who meet criteria outlined by OBH. This includes, but is not limited to, successfully completing an LDH/OBH approved training for RPSS, receiving documented clinical supervision in core competencies from an approved supervisor, and being included on the LDH/OBH roster of Recognized Peer Support Specialists.

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

Referral Services – Health care services provided to Enrollees to both in- and out-of-Network Providers when ordered and approved by the Contractor, including, but not limited to in-network specialty care and out-of-network services that are covered under the State Plan.

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

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

Reinsurance – An agreement between insurance companies, whereby the ceding insurer transfers some part of its insurance liabilities to the assuming insurer, in accordance with La. R.S. 22:651, et seq.

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

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

Reprocessing (Claims) – Upon determination of the need to correct the outcome of one or more Claims processing transactions, the subsequent attempt to process a single Claim or batch of Claims.

Request for Proposals (RFP) – The document and any subsequent addenda issued by LDH and results in this Contract.

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

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

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

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

Rural Area – Any area outside an urban area.

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

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

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

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

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

Service Area – The designated area in which the Contractor is authorized to furnish MCO Covered Services to Enrollees. The service area is the entire State of Louisiana.

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

Shall – Denotes a mandatory requirement.

Should – Denotes a desirable action, but not a mandatory requirement.

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

Single Transportation Broker – The single entity designated by LDH to manage the coordination and provision of Non-Emergency Medical Transportation services in accordance with 42 CFR §440.170(a)(4).

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

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

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

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

Span of Control – Information systems and telecommunications capabilities that the Contractor operates or for which it is otherwise legally responsible according to the terms and conditions with LDH. The Span of Control also includes systems and telecommunications capabilities outsourced by the Contractor.

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

Specialist* – A physician who is not a PCP. May be used interchangeably with subspecialist.

Specialized Behavioral Health Services (SBHS) – Mental health services and substance use services that are provided outside of primary care, unless furnished in an integrated care setting, and include, but are

not limited to, services provided by a psychiatrist, LMHP, and/or mental health rehabilitation provider.

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

State – The State of Louisiana.

State Fair Hearing – The process set forth in 42 CFR Subpart E.

State Plan – Refers to the Louisiana Medicaid State Plan and the LaCHIP State Plan.

Stop-Loss Coverage - Insurance covering the loss of an insured above a specific amount. Also referred to as "excess loss coverage".

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

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

Subcontractor – A person, agency or organization with which the Contractor has subcontracted or delegated some of its management functions or other contractual responsibilities to provide MCO Covered Services to its Enrollees. A Network Provider is not a Subcontractor by virtue of the Network Provider agreement with the Contractor.

Subsidiary – An Affiliate that is owned or controlled by the Contractor, either directly or indirectly through one (1) or more intermediaries.

Subspecialist – A physician who is not a PCP. May be used interchangeably with specialist.

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

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

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

- Record Search Time - the time elapsed after the search command is entered until the list of matching records begins to appear on the monitor.
- Record Retrieval Time - the time elapsed after the retrieve command is entered until the record data begin to appear on the monitor.
- Print Initiation Time - the elapsed time from the command to print a screen or report until it appears in the appropriate queue.

- On-line Claims Adjudication Response Time - the elapsed time from the receipt of the transaction by the MCO from the provider and/or switch vendor until the MCO hands-off a response to the provider and/or switch vendor.

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

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

Targeted Case Management – Case Management services for targeted population groups and certain Waiver groups, in accordance with applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, and Waivers.

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

Tenancy Supports – Supports provided under CPST and PSR to that subset of Enrollees accepted for participation in Louisiana's PSH Program. Tenancy and pre-tenancy supports are designed to help Enrollees access and maintain successful tenancy in the community-integrated, affordable housing provided through Louisiana's PSH Program. Tenancy and pre-tenancy supports consist of activities such as helping Enrollees complete apartment applications, seek reasonable accommodations, negotiate and enter into leases, understand the role of tenant, understand tenant rights, develop budgets, make Timely rent payments, comply with terms of lease, adjust to new home and neighborhood (including how to get to and access essential services), apply for income benefits such as SSI, comply with medication and other treatment regimes, and develop/implement crisis plans to avoid eviction.

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

Third Party Liability (TPL) – Refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under the State Plan. By law, all other available third party resources must meet their legal obligation to pay Claims before the Louisiana Medicaid Program pays for the care of a Beneficiary.

Timely – Existing or taking place within the designated period or within the time required by applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, Waivers, and this Contract.

Title IV-E – Means Title IV, Part E, of the Social Security Act, 42 U.S.C. §§670-679c, which provides for the Federal-State foster care, prevention, and permanency program.

Title V – Means Title V of the Social Security Act, 42 U.S.C. §§701-713, which provides for maternal and

child health services. Federal laws and regulations mandate cooperation between State agencies responsible for the administration and supervision of both Title V and Title XIX of the Social Security Act.

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

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

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

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

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

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

Transportation Broker – Entity that manages the coordination and provision of Non-Emergency Medical Transportation services in accordance with 42 CFR §440.170(a)(4).

Treatment Planning – An administrative treatment planning activity provided under Medicaid requirements at 42 CFR §438.208(c) for developing and facilitating implementation of POCs for Enrollees with SHCN and other Enrollees as required under applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, Waivers, and this Contract. Treatment Planning is provided to address the unique needs of clients living in the community and does not duplicate any other Medicaid Covered Service or services otherwise available to the Beneficiary at no cost.

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

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

Urban Area – A Metropolitan Statistical Area (MSA), as defined by the Executive Office of Management and Budget and applied to Census Bureau data. The most recent delineation files and maps are located at https://www.census.gov.

Urgent Care* – Medical care provided for a condition that without Timely treatment, could be expected

to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily functions, or cause the development of a chronic illness or need for a more complex treatment. Examples of conditions that require urgent care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, and suspected fracture. Urgent care requires Timely face-to-face medical attention within twenty-four (24) hours of Enrollee notification of the existence of an urgent condition.

Utilization – The rate patterns of service usage or types of service occurring within a specified time.

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

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

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

Value-Added Benefit (VAB) – The additional benefits outside of the MCO Covered Services that are delivered at the Contractor's discretion and are not included in the Capitation Rate calculations. Value-added benefits do not include in lieu of services.

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

Voluntary MCO Population – The groups of Beneficiaries who are not required to enroll in the Managed Care Program.

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

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

Will – A term that denotes a mandatory requirement.

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

Acronyms

ABA – Applied Behavior Analysis

ACD – Automated Call Distribution

ACE – Adverse Childhood Experience

ACH – Automated Clearinghouse

ACT – Assertive Community Treatment

ADA – Americans with Disabilities Act

ADHC – Adult Day Health Care

ADT—Admit Discharge Transfer

APM – Alternative Payment Model

APRN - Advanced Practice Registered Nurse

ARRA—American Recovery and Reinvestment Act

ASAM – American Society of Addiction Medicine

ASC – Accredited Standards Committee

ASL—American Sign Language

BCC – Breast and Cervical Cancer

BCP – Business Continuity Plan

BHSF – Bureau of Health Services Financing

CAHPS – The Consumer Assessment of Health Providers and Systems

CANS – Child and Adolescent Needs and Strengths

CAP – Corrective Action Plan

CAQH -- Council for Affordable Quality Healthcare

CARF -- Commission on Accreditation of Rehabilitation Facilities

CBO – Community-based Organizations

CC – Children's Choice

CCW – Community Choices Waiver

CDC – Centers for Disease Control and Prevention

CEHRT—Certified Electronic Health Record Technology

CEO—Chief Executive Officer

CFR – Code of Federal Regulations

CHAMP – Child Health and Maternal Program

CHIP – Children's Health Insurance Program

CHW – Community Health Worker

CI – Crisis Intervention

CLAS – Culturally and Linguistically Appropriate Services

CLIA – Clinical Laboratory Improvement Amendments

CMO – Chief Medical Officer

CMS – Centers for Medicare and Medicaid Services

COA – Council on Accreditation

COB – Coordination of Benefits

COLA – Cost of Living Adjustment

CON – Certification of Need

COO – Chief Operating Officer

CPST – Community Psychiatric Support and Treatment

CPT – Current Procedural Terminology

CQI – Continuous Quality Improvement

CSoC – Coordinated System of Care

CVO – Credentials Verification Organization

CY – Calendar Year

DBPM – Dental Benefit Program Manager

DBT – Dialectical Behavior Therapy

DCFS – Department of Children and Family Services

DD – Developmentally Disabled

DME – Durable Medical Equipment

DOI – Louisiana Department of Insurance

DOS – Date(s) of Service

DRA – Deficit Reduction Act

DRP – Disaster Recovery Plan

DSA – Data Sharing Agreement

DSH – Disproportionate Share Hospital

DUR – Drug Utilization Review

EB – Enrollment Broker

EBP – Evidenced Based Practices

ED – Emergency Department

EDI – Electronic Data Interchange

EFT – Electronic Funds Transfer

EHR – Electronic Health Records

EOB – Explanation of Benefits

EPO – Exclusive Provider Organizations

EPSDT – Early and Periodic Screening, Diagnosis and Treatment

EQR – External Quality Review

EQRO – External Quality Review Organization

EVV – Electronic Visit Verification

FDA – Food and Drug Administration

FFP – Federal Financial Participation

FFS – Fee-for-Service

FFT – Functional Family Therapy

FI – Fiscal Intermediary

FITAP – Family Independence Temporary Assistance Program

FMP – Full Medicaid Pricing

FNS – Facility Notification System

FOC – Freedom of Choice

FQHC – Federally Qualified Health Center

FSO – Family Support Organization

GAO – Government Accountability Office

GME – Graduate Medical Education

GPRA – Government Performance Reporting and Results Act

HCBS – Home and Community Based Services Waiver

HCP-LAN – Health Care Payment Learning and Action Network

HEDIS – Healthcare Effectiveness Data and Information Set

HHS – United States Department of Health and Human Services

HIE – Health Information Exchange

HIPAA – Health Insurance Portability and Accountability Act

HITECH – Health Information Technology for Economic and Clinical Health Act

HNA – Health Needs Assessment

HPE – Hospital Presumptive Eligibility

HPSA – Health Professional Shortage Area

HRSA – Health Resources and Services Administration

HSIC – Human Services Interagency Council

HSS – Health Standards Section

IB – Incentive-based

ICF/IID – Intermediate Care Facility for Individuals with Intellectual Disabilities

ICN – Internal Control Number

I/DD – Intellectual/Developmental Disability

ID – Identification

IEP – Individualized Education Plan

IHCP – Indian Health Care Provider

IHS – Indian Health Service

IMD – Institution for Mental Diseases

IRS – Internal Revenue Service

IS – Information Systems

ISA – Interoperability Standards Advisory

ISCA – Information Systems Capabilities Assessment

IVR – Interactive Voice Response

IV&V – Independent Verification and Validation

JLCB – Joint Legislative Committee on the Budget

LAALS – Louisiana Adverse Actions List Search

LAC – Licensed Addiction Counselor

LaCHIP – Louisiana Children's Health Insurance Program

LaHIPP – Louisiana Health Insurance Premium Payment Program

LCH – Louisiana Crisis Hub

LCSW – Licensed Clinical Social Worker

LDH – Louisiana Department of Health

LDOE – Louisiana Department of Education

LEERS – Louisiana Electronic Event Registration System

LEIE – List of Excluded Individuals/Entities

LGE – Local Governing Entity

LHA – Louisiana Housing Authority

LLA – Louisiana Legislative Auditor

LMFT – Licensed Marriage and Family Therapists

LMHP – Licensed Mental Health Professional

LPC – Licensed Professional Counselors

LOCUS – Level of Care Utilization System

LTC – Long Term Care

LTSS – Long-Term Supports and Services

MAC – Maximum Allowable Cost

MAT – Medication Assisted Treatment

MCIP – Managed Care Incentive Program

MCO – Managed Care Organization

MEF – Medicaid Exclusion File

MFCU – Medicaid Fraud Control Unit

MHR – Mental Health Rehabilitation

MIS – Management Information System

MLR – Medical Loss Ratio

MMIS – Medicaid Management Information System

MOU – Memorandum of Understanding

MST – Multi-Systemic Therapy

MVA – Medical Vendor Administration

NCCI – National Correct Coding Initiative

NCQA – National Committee for Quality Assurance

NDC – National Drug Code

NEAT – Non-Emergency Ambulance Transportation

NEMT – Non-Emergency Medical Transportation

NF – Nursing Facility

NICU – Neonatal Intensive Care Unit

NIST – National Institute of Standards and Technology

NMP – Notice of Monetary Penalty

NOA – Notice of Action

NOMS – National Outcome Measures

NOW – New Opportunities Waiver

NP – Nurse Practitioner

NPI – National Provider Identifier

NQTL – Nonquantitative Treatment Limitations

OCDD – Office for Citizens with Developmental Disabilities

OCR – Optical Character Recognition

ODBC – Open Database Connectivity

OEM – Original Equipment Manufacturer

OIG – Office of Inspector General

OJJ – Office of Juvenile Justice

OLE – Object Linking and Embedding

OMH – Office of Minority Health

ONC – Office of the National Coordinator

OON – Out-of-Network

OPH – Office of Public Health

P&T – Pharmaceutical and Therapeutic Committee

PA – Prior Authorization

PACE – Program of All-Inclusive Care for the Elderly

PASRR – Pre-Admission Screening and Resident Review

PBM – Pharmacy Benefits Manager

PCMH – Patient-Centered Medical Home

PCN – Processor Control Number

PCP – Primary Care Provider

PCS – Personal Care Services

PDL – Preferred Drug List

PHI – Protected Health Information

PIP – Performance Improvement Projects

PMPM – Per Member, Per Month

POC – Plan of Care

POS – Point of Sale

PPACA – Patient Protection and Affordable Care Act

PPS – Prospective Payment System

PRTF – Psychiatric Residential Treatment Facilities

PSH – Permanent Supportive Housing

PSR – Psychosocial Rehabilitation

PT – Physical Therapy

QA – Quality Assurance

QAPI – Quality Assessment and Performance Improvement

QDWI – Qualified Disabled Working Individual

QI – Quality Improvement

QI-1 – Qualifying Individual

QM – Quality Management

QMB – Qualified Medicare Beneficiary

QM/QI – Quality Management/Quality Improvement

RA – Remittance Advice

RAC – Recovery Audit Coordinator

RDBMS – Relational Database Management System

RFP – Request for Proposals

RHC – Rural Health Clinic

RN – Registered Nurse

ROW – Residential Options Waiver

RPSS – Recognized Peer Support Specialist

RSDI – Retirement, Survivors, and Disability Insurance

SAM – System of Award Management

SBHC – School Based Health Center

SBHS – Specialized Behavioral Health Services

SDF – Software Development Firm

SDOH – Social Determinants of Health

SFTP – Secure File Transfer Protocol

SFY – State Fiscal Year

SHCN – Special Health Care Needs

SHP – STD /HIV Program

SIU – Special Investigation Unit

SLMB – Specified Low-Income Medicare Beneficiary

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

SMI – Serious Mental Illness

SNAP – Supplemental Nutrition Assistance Program

SPA – State Plan Amendment

SSA – Social Security Act

SSI – Supplemental Security Income

SUD – Substance Use Disorder

SURS – Surveillance and Utilization Review Subsystems

TCOC – Total Cost of Care

TDD – Telecommunications Device for the Deaf

TEDS – Treatment Episode Data Sets

TGH – Therapeutic Group Home

TJC – The Joint Commission

TPL – Third Party Liability

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

UM – Utilization Management

UPS – Uninterruptible Power System

UR – Utilization Review

U.S.C. – United States Code

VAB – Value Added Benefit

VBP – Value-Based Payment

VPN – Virtual Private Network

WAA – Wraparound Agency

WIC – Special Supplemental Nutrition Program for Women, Infants, and Children

PART 2: CONTRACTOR RESPONSIBILITIES

2.1 Contract Transition & Readiness

2.1.1 Transition Phase

2.1.1.1 The Contractor shall submit to LDH or its designee as requested, for its review and approval, a Transition Work Plan that demonstrates how it will accomplish required tasks set forth in this Contract before the Operational Start Date and provide documentation of the following:

2.1.1.1.1 Project management structure;

2.1.1.1.2 Communication protocols between LDH and the Contractor;

2.1.1.1.3 Contacts for readiness activities;

2.1.1.1.4 Schedule for key activities and milestones; and

2.1.1.1.5 Process for ensuring continuity of care for Enrollees during the transition with a focus on health and safety.

2.1.1.2 The Contractor shall provide monthly status reports that track implementation progress against the schedule in the Transition Work Plan, as approved by LDH in writing, for six (6) months following the Operational Start Date.

2.1.2 Readiness Review

2.1.2.1 LDH or its designee may conduct a comprehensive Readiness Review of the Contractor prior to the Operational Start Date in accordance with 42 CFR §438.66(d). LDH will provide the Contractor with the Readiness Review schedule, if applicable. The Contractor agrees to provide all materials required to complete the Readiness Review by the dates established by LDH. The review may include an evaluation of all deliverables as defined in the Contract. A portion of the Readiness Review will be performed onsite at the Contractor's administrative office. The Contractor shall be responsible for all travel costs incurred by LDH, or its designee's, staff participating in onsite Readiness Reviews. The results of the Readiness Review will be submitted to CMS by LDH for CMS to make a determination that the contract or associated contract amendment is approved under 42 CFR §438.3(a).

2.1.2.2 The Contractor must disclose any changes to proposed key staff, Subcontractors, or Value-Added Benefits identified in the proposal for LDH approval.

2.1.2.3 The Contractor must have successfully met all Readiness Review requirements established by LDH no later than sixty (60) Calendar Days prior to the Operational Start Date or by the dates established by LDH in writing when applicable.

2.1.2.4 If the Contractor does not fully meet the Readiness Review prior to the Operational Start Date, LDH may impose a Monetary Penalty for each Calendar Day beyond the Operational Start Date that the Contractor is not operational.

2.1.2.5 The Contractor is required to provide a Corrective Action Plan in response to any Readiness Review deficiency no later than ten (10) Calendar Days after written notification of any such deficiency by LDH or its designee. If the Contractor documents to LDH's satisfaction that the deficiency has been corrected within ten (10) Calendar Days of such deficiency notification by LDH or its designee, no Corrective Action Plan is required.

2.1.2.6 System Readiness

2.1.2.6.1 The Contractor will define and test modifications to the Contractor's system(s) required to support the business functions of the Contract. The Contractor will produce data extracts and receive data transfers and transmissions. The Contractor must be able to demonstrate the ability to produce Encounter files.

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

2.1.2.7 The Contractor shall participate in additional Readiness Reviews as required by LDH and when providing or arranging for the provision of MCO Covered Services to new eligibility groups in accordance with 42 CFR §438.66(d)(1) as directed by LDH.

2.1.2.8 If a Readiness Review is not required, the Contractor shall provide all documents that would have been submitted during the Readiness Review, as specified in the Contract, as requested by LDH.

2.2 Administration & Contract Management

2.2.1 General Requirements

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

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

2.2.1.3 The Contractor shall require its Subcontractors to comply with all applicable Contract requirements, applicable Federal and State laws,

regulations, rules, policies, procedures, and manuals, the State Plan, Waivers, and applicable subregulatory guidance.

2.2.1.4 The Contractor shall cooperate with LDH, CMS, the External Quality Review Organization (EQRO), and any other LDH contractors related to the operation, evaluation, and monitoring of this Contract, the Contractor, or the Managed Care Program.

2.2.1.5 The Contractor and all Subcontractors shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under this Contract. This requirement shall be inclusive of Material Subcontracts with entities who manage or coordinate certain benefits for Enrollees on behalf of the MCOs but do not directly provide the service to Enrollees. When requested by the MFCU, the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the Contractor or its Subcontractor shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records, or data. The Contractor and/or Subcontractor shall agree that the Contract and/or subcontract create for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

2.2.2 Staffing Requirements

2.2.2.1 General Staffing Requirements

2.2.2.1.1 The Contractor shall have in place an organizational and governance structure capable of fulfilling all Contract requirements. The Contractor shall recruit, develop, and retain a diverse and qualified staff in numbers appropriate to the Contractor's Enrollment, as described further below.

2.2.2.1.2 The Contractor's staffing and resource allocation shall be adequate to achieve positive outcomes and comply with the requirements of the Contract and the **MCO Manual**, including the requirement for providing culturally competent services. If the Contractor does not achieve the desired outcomes or maintain compliance with contractual obligations, non-compliance action(s) may be employed by LDH, including but not limited to, requiring the Contractor to hire additional staff and the application of Monetary Penalties as specified in Attachment G, *Table of Monetary Penalties*.

2.2.2.1.3 The Contractor shall provide and have a staffing plan approved by LDH in writing that describes how the Contractor shall maintain the staffing level to ensure the successful accomplishment of all contractual duties.

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

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

2.2.2.1.4.2 Louisiana Adverse Actions List Search;

2.2.2.1.4.3 The System of Award Management (SAM); and

2.2.2.1.4.4 Other applicable sites as may be determined by LDH.

2.2.2.1.5 The Contractor shall comply with LDH Policy 47.1, "Criminal History Records Check of Applicants and Employees," which requires the Contractors to conduct criminal background checks on potential and current employees or Subcontractors who have access to Enrollee Protected Health Information (PHI). The Contractor shall, upon request, provide LDH with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or Subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this Contract.

2.2.2.1.6 The Contractor shall submit to LDH or its designee a listing of its Board of Directors during Readiness Review and an updated listing of its Board of Directors whenever any changes are made.

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

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

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

2.2.2.2 Substitution of Personnel

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

2.2.2.3 Exceptions to Staffing Requirements

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

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

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

2.2.2.4 Key Personnel Requirements

2.2.2.4.1 The Contractor shall identify the individuals serving as key personnel. Unless the Contractor requests and receives a written exception from LDH, all key personnel shall be full-time employees (minimum forty (40) hours per week), based in Louisiana, dedicated one hundred percent (100%) to this Contract, and serve in only one key personnel position.

2.2.2.4.1.1 If an individual is not required to, and does not, serve exclusively in their key personnel position, the Contractor shall provide to LDH, in writing, a description of the individual's other responsibilities. Such description shall also be provided with the Contractor's request for an exception from LDH, if applicable.

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

2.2.2.4.3 The Contractor shall seek prior written approval from LDH for all key personnel positions before a candidate is hired.

2.2.2.4.4 The following positions are designed as key personnel:

2.2.2.4.4.1 The **Chief Executive Officer (CEO)** shall provide overall direction for this Contract, develop strategies, formulate policies, and oversee operations to ensure goals are met. The CEO shall be the primary contact for LDH regarding all issues and shall coordinate with other key personnel to fulfill the requirements of the Contract. The CEO shall attend all CEO designated meetings in person as requested by LDH. If the CEO us unable to attend, a designee may attend with advance notification to LDH.

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2.2.2.4.4.2 The **Chief Operating Officer (COO)** shall manage day-to-day operations of multiple levels of staff and multiple functions/departments across the Contractor's organization to meet the performance requirements of the Contract. The COO shall be accountable to the CEO for operational results and may be designated to serve as the primary point-of-contact for all MCO operational issues. The COO shall serve exclusively in this position and may not function in an Executive Capacity for another insurance product. The COO shall attend meetings in person, when requested.

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

Development, implementation, and medical interpretation of clinical policies and procedures, including, but not limited to, Service Authorization, Claims review, discharge planning, credentialing and referral management, utilization management and medical review included in the MCO Grievance System;

Administration of all medical management activities of the Contractor;

Coordinating with the Behavioral Health Medical Director

to integrate the administration and management of behavioral and physical health services;

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

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

2.2.2.4.4.4 The **Behavioral Health Medical Director** shall be a physician with a current, unencumbered license through the Louisiana State Board of Medical Examiners. The Behavioral Health Medical Director shall be board-certified in psychiatry with at least three (3) years of training in a medical specialty. The Behavioral Health Medical Director shall ensure Timely medical decisions, including after-hours consultation, as needed. During periods when the Behavioral Health Medical Director is not available, the Contractor shall have physician staff available to provide competent medical direction. The Behavioral Health Medical Director shall serve exclusively in this position and may not function in an Executive Capacity for another insurance product. The Behavioral Health Medical Director shall attend meetings in person, when requested.

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

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

Provide clinical case management consultations and clinical guidance for contracted Primary Care Providers (PCPs) treating behavioral health-related concerns not requiring referral to behavioral health specialists;

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

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

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

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

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

2.2.2.4.4.5 The **Chief Financial Officer (CFO)** shall oversee the budget, accounting systems, financial reporting, and all audit activities implemented by the Contractor. The CFO shall serve exclusively in this position and may not function in an Executive Capacity for another insurance product. The CFO shall attend meetings in person, when requested.

2.2.2.4.4.6 The **Pharmacy Director** shall be licensed in Louisiana, with at least five (5) years' experience as a pharmacist practicing in a retail setting with managerial experience. The Pharmacy Director shall serve exclusively in this position and may not function in a similar capacity for another insurance product. The Pharmacy Director shall attend meetings in person, when requested.

2.2.2.4.4.7 The **Contract Compliance Officer** shall serve as the primary point of contact for all communications and requests related to this Contract, including, but not limited to, all compliance issues. The Contract Compliance Officer shall manage the connection of Contractor personnel to LDH Business Owners, and shall develop and implement written policies, procedures, and standards to ensure compliance with the requirements of this Contract. These primary functions may include, but are not limited to, coordinating the tracking and submission of all Contract deliverables, fielding and coordinating responses to LDH inquiries, coordinating the preparation and execution of Contract documents, audits and ad hoc

visits. This position shall report directly to the CEO and board of directors in accordance with 42 CFR §438.608(a)(1)(ii). The Contract Compliance Officer shall attend meetings in person, when requested.

2.2.2.4.4.8 The **Health Equity (HE) Administrator** shall serve as the single point of contact responsible and accountable for all matters related to health equity within the Contractor's organization and provider network to support the effectiveness and efforts of the Contractor's Health Equity Plan. The Contractor may hire or designate an existing employee to serve as the HE Administrator. The HE Administrator must be a high-level employee (i.e., director level or above) but may have more than one area of responsibility and job title. The roles and responsibilities of the HE Administrator are to:

Oversee the Contractor's strategic design, implementation, and evaluation of health equity efforts in the context of the Contractor's population health initiatives;

Inform decision-making around best payer practices related to disparity reductions, including the provision of health equity and social determinant of health resources and research to leadership and programmatic areas;

Inform decision-making regarding best payer practices related to disparity reductions, including providing Contractor teams with relevant and applicable resources and research and ensuring that the perspectives of Enrollees with disparate outcomes are incorporated into the tailoring of intervention strategies;

Collaborate with the Contractor's Chief Information Officer to ensure the Contractor collects and meaningfully uses race, ethnicity, language, disability and geographic data to identify disparities;

Coordinate and collaborate with Enrollees, providers, local and State government, community-based organizations, LDH, and other LDH contracted managed care entities to impact health disparities at a population level; and

Ensure that efforts addressed at improving health equity, reducing disparities, and improving cultural competence are designed collaboratively and that lessons learned are incorporated into future decision-making.

2.2.2.5 Additional Required Staff

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

2.2.2.5.2 The Contractor shall maintain at least fifty percent (50%) of its staff within the State of Louisiana.

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

2.2.2.6 Written Policies, Procedures, and Job Descriptions

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

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

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

2.2.2.7 Staff Training, Licensure, and Meeting Attendance

2.2.2.7.1 The Contractor shall ensure that all staff members, including Subcontractors, have met any applicable State or Federal licensure and/or certification requirements and have received appropriate training, education, experience and orientation to fulfill their requirements of the position. The Contractor shall prohibit any staff person and/or Subcontractor who has failed to comply with any requirement in the preceding sentence from performing any work under the Contract unless and until the staff person and/or Subcontractor has achieved compliance with all requirements. LDH may require additional

staffing for the Contractor that has substantially failed to maintain compliance with any provision of the Contract.

2.2.2.7.2 The Contractor shall provide initial and ongoing staff training that includes an overview of contractual, State and Federal requirements specific to individual job functions. The Contractor shall ensure that all staff members having contact with Enrollees or providers receive initial and ongoing training on health equity and social determinants of health, beyond Culturally and Linguistically Appropriate Services (CLAS) requirements and with regard to the appropriate identification and handling of quality of care concerns.

2.2.2.7.3 The Contractor shall educate all staff members about its policies and procedures on Advance Directives.

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

2.2.2.7.5 The Contractor shall comply with the cybersecurity training requirements of this Contract.

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

2.2.2.7.6.1 For case managers and case management supervisors:

Specialized behavioral health policy and procedure manuals issued by LDH;

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

OJJ system, population, and processes;

DCFS system, population, and processes;

Contract requirements;

Approved Waivers and State Plan amendments (SPAs) for specialized behavioral health;

Specialized Behavioral Health Services (SBHS) for Enrollees residing in a nursing facility and/or included in the DOJ Agreement Target Population;

Pre-admission screening and resident review (PASRR);

Services provided by the Office for Citizens with Development Disabilities;

Current and applicable evidence-based practices;

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

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

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

2.2.2.7.6.3 For staff members working directly with Enrollees – crisis intervention training.

2.2.2.7.6.4 For employees and Subcontractors performing work or services related to the performance or supervision of audits, Prior Authorizations, and clinical reviews of mental health rehabilitation services providers – annual training on the LDH Behavioral Health Provider Manual and the relevant State laws, policies, and regulations related to the State's mental health rehabilitation program.

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

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

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

2.2.3 Material Subcontracts/Subcontractors

2.2.3.1 Prior to contracting with a Material Subcontractor, the Contractor shall evaluate the prospective Material Subcontractor's ability to perform the activities to be subcontracted.

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

2.2.3.3 The Contractor shall provide LDH with any information requested by LDH in writing in addition to the information required in the checklist, including identifying whether the proposed Material Subcontractor is part of an organization related to the Contractor.

2.2.3.4 All Subcontracts shall:

2.2.3.4.1 Be written;

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

2.2.3.4.3 Provide for imposing penalties, up to and including Contract termination, if the State or the Contractor determines that the Subcontractor's performance is inadequate or non-compliant;

2.2.3.4.4 Require the Subcontractor to comply with all applicable Contract requirements, applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, Waivers, and applicable subregulatory guidance;

2.2.3.4.5 Stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the State law where the Subcontractor is based and Louisiana law.

2.2.3.4.6 Comply with the requirements set forth in 42 CFR §438.230(c)(3) and CFR§438.3(k).

2.2.3.5 The State, including LDH, MFCU, and the Louisiana Legislative Auditor (LLA), and the Federal government, including, CMS, OIG, and the Comptroller General, or their designees, shall have the right to audit, evaluate, and inspect any records or systems that pertain to any activities performed or amounts payable under this Contract at any time.

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

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

2.2.3.5.3 The Contractor and any Subcontractors shall retain, as applicable, Enrollee Grievance and Appeal records under 42 CFR §438.416; base data under 42 CFR §438.5(c); MLR reports under 42 CFR §438.8(k); and the data, information, and documentation specified in 42 CFR §438.604, §438.606, §438.608, and §438.610 for a period of no less than ten (10) years following termination of the Contract; and

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

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

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

2.2.3.9 As required by 42 CFRCFR §438.3(k), §438.230(a) and §438.230(b)(1),(2), the Contractor shall be responsible to oversee all Subcontractors' performance and shall be held accountable for any function and responsibility that it delegates to any Subcontractor.

2.2.3.10 In the event of a transition between Subcontractors during the term of this Contract, the Contractor must ensure that the original Subcontractor fulfills all subcontractual obligations, including those that survive the subcontract termination or expiration. In the event that the Contract terminates or expires, the Contractor must ensure that any existing Subcontractor fulfills its subcontractual obligations including those that survive Contract termination.

2.2.3.11 Use of a Transportation Broker

2.2.3.11.1 If the Contractor elects to subcontract with a Transportation Broker to coordinate Non-Emergency Medical Transportation (NEMT) and/or Non-

Emergency Ambulance Transportation (NEAT) services, the Contractor shall subcontract with and provide remuneration to the Single Transportation Broker designated by LDH. LDH has the sole discretion to establish the subcontract terms.

2.2.3.11.2 The Contractor shall not make amendments to the Single Transportation Broker subcontract without prior written approval from LDH.

2.2.3.11.3 If the Contractor elects to subcontract with a Transportation Broker and the Single Transportation Broker is not operational by the Operational Start Date, the following provisions apply:

2.2.3.11.3.1 If the Contractor is not a New Entrant, the Contractor shall continue to subcontract with its existing Transportation Broker subject to the requirements of this Contract.

2.2.3.11.3.2 If the Contractor is a New Entrant, the Contractor shall subcontract with the FFS Transportation Broker or a Transportation Broker that is subcontracted with another MCO, subject to the requirements of this Contract.

2.2.3.11.3.3 The Contractor may subcontract with a different Transportation Broker, with prior written approval from LDH.

2.2.3.11.3.4 The provisions of this section are rendered invalid once the Single Transportation Broker is operational, subject to a reasonable transition period, as determined by LDH.

2.2.3.12 Use of a Pharmacy Benefits Manager (PBM)

2.2.3.12.1 If the MCO utilizes a PBM for pharmacy claims payment and administrative services, then the Contractor and its PBM shall comply with the following requirements:

2.2.3.12.1.1 The Contractor shall identify the proposed PBM and the ownership of the proposed PBM. Before entering into a subcontract with a PBM, the contractor shall obtain written approval from LDH. The Contractor shall submit a written description of the assurances and procedures that shall be put in place under the proposed PBM subcontract, such as an independent audit, to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information. The Contractor shall provide a plan documenting how it will monitor such PBM. These assurances and procedures shall be transmitted to LDH for review and approval prior to the Operational Start Date.

2.2.3.12.1.2 The Contractor shall submit a plan for oversight of the PBM's performance prior to the implementation of the Contractor's PBM. The plan shall be subject to LDH approval and comply with this Contract and all LDH requirements.

2.2.3.12.1.3 The Contractor's PBM shall not deny any Louisiana-licensed pharmacy or Louisiana-licensed pharmacist the right to be a participating provider in the Contractor or PBM provider network if the pharmacy or pharmacist is in good standing and meets all requirements of participation in the Louisiana Medicaid program.

2.2.3.12.1.4 Any contract for PBM services shall be a direct contract with the Contractor:

2.2.3.12.1.4.1 As payment in-full for the services performed under the contract, the Contractor shall pay the PBM an all-inclusive administrative fee, calculated by multiplying the number of processed claims by a transaction fee, which shall not exceed $1.25 per pharmacy claim processed.

2.2.3.12.1.4.2 In accordance with La. R.S. 46:450.7, the contract shall prohibit "spread pricing," defined as any amount charged or claimed by a PBM to the Contractor that is in excess of the amount paid to the dispensing pharmacy, including the ingredient cost, provider fee and dispensing fee.

2.2.3.12.1.4.3 The PBM or other Subcontractor shall provide the MCO pharmacy staff real-time, unredacted, read access to view the pharmacy claims processing system and prior authorization records, at no cost to the Contractor.

2.2.3.12.1.4.4 The PBM shall coordinate with the Contractor the dissemination of materials to enrollees and providers such that the Contractor can obtain the appropriate prior approvals from LDH, when necessary.

2.2.3.12.1.4.5 If the PBM contracts with a subcontractor, the Contractor shall request prior approval of the subcontract and any amendment thereto. To obtain such approval, the Contractor shall submit a written request and a copy of the proposed subcontract. The request shall also describe how the Contractor and PBM will oversee the subcontractor. The Contractor shall provide any additional information requested by LDH. LDH shall review and approve or deny the subcontractor contract.

2.2.3.12.1.4.6 The PBM shall not make or allow any direct or indirect reduction of payment to a pharmacist or pharmacy for a drug, device, or service under a reconciliation process to an effective rate of reimbursement, including, but not limited to, generic effective rates, brand effective rates, direct and

indirect remuneration fees, or any other reduction or aggregate reduction of payment.

2.2.3.12.1.4.7 The Encounter Data completion standard for pharmacy Encounters processed by a PBM shall be a three percent (3%) error threshold (i.e., Encounters are at least ninety-seven percent [97%] but no greater than one hundred percent [100%] of cash disbursements).

2.2.4 Performance Reviews

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

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

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

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

2.2.4.3.1.1 Costs of care for Enrollees by program and category of service;

2.2.4.3.1.2 Performance reporting information;

2.2.4.3.1.3 Quality measure performance;

2.2.4.3.1.4 Measures of Enrollee utilization across categories of service and other indicators of changes in patterns of care;

2.2.4.3.1.5 Variation and trends in any such performance measures at the level of individual PCPs;

2.2.4.3.1.6 Completeness and validity of any data submissions made to LDH;

2.2.4.3.1.7 Opportunities the Contractor identifies to improve performance and plans to improve such performance, including plans proposed to be implemented by the Contractor for PCPs or other Network Providers;

2.2.4.3.1.8 Changes in Contractor's staffing and organizational development;

2.2.4.3.1.9 Performance of Material Subcontractors, including, but not limited to, any changes in or additions to Material Subcontractor relationships; and

2.2.4.3.1.10 Any other measures deemed relevant by Contractor or requested by LDH;

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

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

2.2.4.4 The Contractor shall, within five (5) Business Days following each performance review meeting, prepare and submit to LDH for review and approval a list of any action items, requested follow-ups for the next meeting, and estimated timelines for delivery, in a form and format specified by LDH.

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2.2.5 Continuity of Operations Plan

2.2.5.1 The Contractor shall maintain a Continuity of Operations Plan that addresses how the Contractor's, Material Subcontractors', and other Subcontractors' operations and the ongoing provision of healthcare services shall be maintained in the event of a pandemic, natural disaster or man-made emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies, or other event which leads to a significant disruption in operations due to staff absence and/or loss of utilities that impacts fulfilling the requirements of this Contract. The Continuity of Operations Plan shall be invoked no later than when the fulfillment of these requirements is impacted by such an event.

2.2.5.2 As part of the Continuity of Operations Plan, the Contractor shall provide its action plan for development of an emergency preparedness plan specific to each of its Enrollees with Special Health Care Needs (SHCN) during or following an event as described above. The emergency preparedness plan must be provided to the Enrollee in a manner and format that may be easily understood and is readily accessible. Information in the plan must be communicated in a way that can be understood by Enrollees of varying functional ability and language proficiency. The plan must identify any steps the Enrollee and/or Enrollee's caregiver should take in the event of an emergency including, but not limited to, special considerations regarding medications, supplies and dietary needs, or power outages, as applicable, and corresponding contact information.

2.2.5.3 The Contractor shall follow all LDH directives regarding access to care and relaxation of authorization requirements during an emergency. Corresponding system edits for all services shall be implementable at the parish level during an emergency.

2.2.5.3.1 The Contractor must have a method for ensuring that Prior Authorizations are extended and transferred to new providers during a pandemic, natural disaster, man-made emergency, or other event if directed by LDH.

2.2.5.4 As part of the Continuity of Operations Plan, the Contractor shall provide a systems contingency plan, regardless of its system architecture, to protect the availability, integrity, and security of data and to continue essential application or system functions during and immediately following these events.

2.2.5.4.1 The systems contingency plan shall include, at a minimum:

2.2.5.4.1.1 A disaster recovery plan designed to recover systems, networks, workstations, applications, etc. in the event of a disaster; and

2.2.5.4.1.2 A Business Continuity Plan (BCP) for 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.

2.2.5.4.2 The systems contingency plan shall address the following scenarios, at a minimum:

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

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

2.2.5.4.2.3 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; and

2.2.5.4.2.4 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.

2.2.5.4.3 The systems contingency plan shall specify projected recovery times and data loss for mission-critical Systems in the event of a declared disaster.

2.2.5.4.4 The Contractor shall annually test its plan through simulated disasters and lower level failures in order to demonstrate to LDH that it can restore system functions. The Contractor shall report documentation of this testing in a manner determined by LDH.

2.2.5.4.5 In the event the Contractor fails to demonstrate through these tests that it can restore systems functions, the Contractor shall be required to submit a Corrective

Action Plan to LDH describing how the failure shall be resolved within ten (10) Business Days of the conclusion of the test.

2.2.5.5 The Contractor shall submit the Continuity of Operations Plan to LDH or its designee for approval as part of Readiness Review and no later than thirty (30) Calendar Days prior to implementation of changes.

2.2.5.6 The Contractor shall immediately inform LDH, in writing, when invoking its Continuity of Operations Plan. If the nature of the triggering event renders written notification impossible, the Contractor shall notify LDH of the invocation of the Continuity of Operations Plan through the best available means. If the nature of triggering event renders immediate notification impossible, the Contractor shall inform LDH of the invocation of the Continuity of Operations Plan as soon as possible.

2.2.6 Reports and Requests for Information

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

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

2.2.6.1.2 All reports and associated requirements as specified in this Contract and the **MCO Manual**;

2.2.6.1.3 Any data from their clinical systems, authorization systems, Claims systems, medical record reviews, quality and network monitoring reviews, network management visits, Enrollee interaction, and audits;

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

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

2.2.6.2 The Contractor shall respond to requests for information from LDH within the following timelines:

2.2.6.2.1 Requests from LDH shall be acknowledged in writing within one (1) Business Day and addressed within five (5) Business Days, or within the time-period specified by LDH in the request;

2.2.6.2.2 Requests that originate from the Office of the Governor, the LDH Office of the Secretary, or a Louisiana legislator shall be

addressed within twenty-four (24) hours unless otherwise directed by LDH;

2.2.6.2.3 Requests from the LDH Provider Relations Unit shall be addressed within five (5) Business Days; and

2.2.6.2.4 Requests from the LDH Enrollee Complaints Unit and requests for assistance with locating specialists shall be addressed within seventy-two (72) hours unless there is a clinical indication that it is needed sooner.

2.2.6.3 If the Contractor does not provide the requested information within the timeframes outlined in this Contract or in the LDH request, LDH may assess Monetary Penalties as outlined in this section and Attachment G, *Table of Monetary Penalties*.

2.2.6.4 The Contractor shall comply with the following requirements specific to public records' requests in addition to the requirements in the **MCO Manual**:

2.2.6.4.1 During Readiness Review, the Contractor shall provide LDH, or its designee, with the name of the individual who will serve as the Contractor's point of contact for handling public records' requests. If this point of contact changes at any time during the Contract term, the Contractor shall provide LDH with the updated point of contact immediately.

2.2.6.4.2 If LDH receives a request pursuant to the Louisiana Public Records Act for records that are in the custody of the Contractor, the Contractor shall provide all records to LDH that the Department, in its sole discretion, deems to be responsive to the request, pursuant to the timeline and in the requested format established by LDH.

2.2.6.4.3 If the Contractor receives the public records' request directly, the Contractor shall forward the request via email to the LDH Section Chief of Program Operations and Compliance within one (1) Business Day of receipt. Thereafter, the Contractor shall provide all records to LDH that the Department, in its sole discretion, deems to be responsive to the request, pursuant to the timeline and in the requested format established by LDH.

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

2.2.6.6 The obligations outlined in this section shall survive the termination of the Contract.

2.2.7 Mental Health Parity

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

2.2.7.1.1 The Contractor shall complete and submit documentation and reporting when requestd by LDH as part of the Readiness Review process or for ongoing parity compliance review.

2.2.7.2 The Contractor shall develop and maintain internal controls to ensure mental health parity. The Contractor's utilization practices such as Prior Authorization, standards for medical necessity determination, and network policy, procedures, and practices shall comply with the Federal regulations referenced herein.

2.2.7.2.1 Documentation and reporting may include, but it not limited to, both formal application through policy, training, guidelines and set procedure and informal practice within the operation for all mental health or substance use disorder benefits and medical/surgical benefits.

2.2.7.2.2 As directed by LDH as part of ongoing parity review, the Contractor may be required to cover or change services necessary for compliance, including type and amount, duration and scope of services and change policy or operational procedures in order to achieve and maintain compliance with parity requirements.

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

2.2.7.3 The Contractor shall require that all Subcontractors take such actions as are necessary to ensure compliance with mental health parity requirements. To the extent that the Contractor delegates oversight responsibilities for behavioral health services to a Material Subcontractor, the Contractor shall require that the Material Subcontractor complies with provisions of this Contract relating to mental health parity and that documentation and reporting are compiled and jointly analyzed by the Contractor and Material Subcontractor.

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

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

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

Deleted: The Contractor shall cover, in addition to MCO Covered Services, any service necessary for compliance with the requirements for parity in mental health and substance use disorder benefits based on parity analysis. As directed by LDH as part of ongoing parity review, the Contractor may be required to cover or change services necessary for compliance, including type and amount, duration and scope of services and change ...

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Deleted: The Contractor shall ensure Enrollees receive a notice of Adverse Benefit Determination per 42 CFR §438.915(b) and other sections of this Contract which extend ...

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Deleted: The compliance and review shall be in conjunction with parity analysis on the medical/surgical benefit administration. The Contractor shall require mental health parity ...

2.2.7.3.1 The compliance and review shall be coordinated and integrated with parity analysis on the medical/surgical benefit administration.

2.2.7.4

2.2.7.5 The Contractor shall comply with all other applicable Federal and State laws, regulations, rules, policies, procedures, and manuals relating to mental health parity.

2.3 Eligibility and Enrollment

2.3.1 Mandatory MCO Populations for All MCO Covered Services

Unless otherwise excluded in this section, the following Louisiana Medicaid Program populations are automatically enrolled in the Managed Care Program for all MCO Covered Services:

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

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

2.3.1.1.2 Deemed Eligible Child Program – Infants born to a woman determined eligible for the Louisiana Medicaid Program in any category on the date the infant is born, regardless of whether or not the infant remains with the birth mother, through the infant's first year of life. This includes an infant who is born to a mother who is determined eligible for the Louisiana Medicaid Program retroactive to the date the infant was born;

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

2.3.1.1.4 Former Foster Care Children – Individuals age eighteen (18) through twenty-six (26) who were enrolled in the Louisiana Medicaid Program and in foster care under the responsibility of the State on their eighteenth (18th) birthday;

2.3.1.1.5 Foster Care Children – Children under the age of eighteen (18) who are receiving foster care, kinship guardianship, or adoption assistance under Title IV-E.

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

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

2.3.1.1.6 Regular Medically Needy Program – Individuals and families who meet the non-financial eligibility criteria for Parents and Caretaker Relative, Pregnant Women, or Children Under Age Nineteen (19) and whose income is at or below the Medically Needy Income Eligibility Standard;

2.3.1.1.7 Family Opportunities Act for Disabled Children - Medicaid buy-in program for children under the age of nineteen (19) with disabilities who are not eligible for SSI due to income;

2.3.1.1.8 LaCHIP Program – Uninsured low-income children under the age of nineteen (19) who do not otherwise qualify for the Louisiana Medicaid Program; and

2.3.1.1.9 Blind/Disabled Children and Related Populations – Individuals, generally under the age of nineteen (19), who are eligible for the Louisiana Medicaid Program due to blindness or disability.

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

2.3.1.2.1 Parents and Caretaker Relatives Program - Individuals who are a relative of a dependent child by blood, adoption, or marriage and with whom the child is living, who assumes primary responsibility for the child's care, and meet financial and non-financial eligibility criteria; and

2.3.1.2.2 Regular Medically Needy Program.

2.3.1.3 Pregnant Women – Individuals whose basis of eligibility is pregnancy including:

2.3.1.3.1 LaMOMS Program – Pregnant women who receive full Louisiana Medicaid Program coverage through the end of the calendar month in which the twelve (12) month postpartum period ends; and

2.3.1.3.2 LaCHIP Phase IV Program – Provides full Louisiana Medicaid Program coverage from conception through delivery for low-income uninsured citizen and non-citizen pregnant women and their unborn children who are not otherwise eligible for the Louisiana Medicaid Program.

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

2.3.1.5 Aged, Blind, and Disabled Adults – Individuals who are age sixty-five (65) or older, blind, or have a disability; meet financial eligibility criteria; and do not meet the conditions for inclusion in the Voluntary MCO Populations, mandatory SBHS and Non-Emergency Ambulance Transportation (NEAT) populations, and mandatory SBHS and NEMT populations. These include:

2.3.1.5.1 Supplemental Security Income (SSI) Program – Individuals nineteen (19) years of age and older who receive cash payments under Title XVI of the Social Security Act (Supplemental Security Income); and

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

2.3.1.5.2.1 Disabled Adult Children – Individuals over the age of eighteen (18) who became blind or disabled before the age of twenty-two (22) and lost SSI eligibility on or after July 1, 1987, as a result of entitlement to or increase in Social Security Child Insurance Benefits;

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

2.3.1.5.2.3 Pickle – Individuals who currently receive RSDI; were eligible to receive both RSDI and SSI or Mandatory State Supplement (MSS) in at least one (1) month since April 1, 1977; and lost SSI/MSS eligibility either:

Group One – as the direct result of an RSDI COLA; or

Group Two – due to receipt of or increase in RSDI, other than an RSDI COLA, or receipt of or increase in other income and would again be eligible for SSI except for the RSDI COLAs received since the loss of SSI.

2.3.1.5.2.4 Disabled Widows/Widowers and Disabled Surviving Divorced Spouses Unable To Perform Any Substantial Gainful Activity – Widows/Widowers who became ineligible

for SSI due to the receipt of Social Security Disabled Widows/Widowers Benefits as long as they were receiving SSI for the month prior to the month they began receiving RSDI, they would continue to be eligible for SSI if the amount of the RSDI benefit was not counted as income, and they are not entitled to Medicare Part A; and

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

2.3.1.5.3 Medicaid Purchase Plan Program – Working individuals age sixteen (16) through sixty-four (64) who have a disability as defined by the Social Security Administration that can buy health coverage offered by the Louisiana Medicaid Program;

2.3.1.5.4 Provisional Medicaid Program – Individuals with a disability as defined by the Social Security Administration or age sixty-five (65) or older, and who meet the financial eligibility criteria for SSI, but are not receiving SSI; and

2.3.1.5.5 Aged and related populations - Beneficiaries who are age sixty-five (65) or older and not members of the blind/disabled population or members of the Section 1931 Adult population.

2.3.1.6 Transitional Medicaid Program – Short-term coverage for individuals who lose Parents and Caretaker Relatives or Family Independence Temporary Assistance Program (FITAP, administered by DCFS) eligibility because of an increase in earnings.

2.3.1.7 Tuberculosis (TB) Infected Individual Program - Individuals who have been diagnosed as, or are suspected of, being infected with TB.

2.3.1.8 Adult Group – Individuals age nineteen (19) through sixty-four (64), not pregnant, not entitled to or enrolled in Medicare Part A or Part B, and not otherwise eligible for the Louisiana Medicaid Program.

2.3.1.9 Act 421 Children's Medicaid Option – Children under the age of nineteen (19), who have a disability as defined by the Social Security Administration and meet the level-of-care for a nursing facility, hospital, or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

2.3.2 Voluntary MCO Populations

The Contractor shall accept Enrollment of the following Louisiana Medicaid Program populations and provide for all Applied Behavior Analysis (ABA), SBHS, and NEMT/NEAT to all Medicaid Covered Services.

2.3.2.1 If any such Beneficiary voluntarily enrolls in the Managed Care Program for all other Medicaid Covered Services, the Contractor shall provide for all services as specified in the Services section. These populations include:

2.3.2.1.1 Non-dually eligible Beneficiaries receiving services through the following 1915(c) Home and Community-Based (HCBS) Waivers and any HCBS Waiver(s) that replaces these current Waivers:

2.3.2.1.1.1 Adult Day Health Care Waiver (ADHC) – Direct care in a licensed adult day health care facility for those individuals age twenty-two (22) and older who would otherwise require nursing facility services;

2.3.2.1.1.2 New Opportunities Waiver (NOW) – Services to individuals age three (3) and older who would otherwise require ICF/IID services;

2.3.2.1.1.3 Children's Choice Waiver (CC) – Supplemental support services to disabled children from birth to age twenty (20) on the NOW registry;

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

2.3.2.1.1.5 Supports Waiver – Services to individuals eighteen (18) years of age and older with a developmental disability which manifested prior to age twenty-two (22); and

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

2.3.2.1.2 Beneficiaries under the age of twenty-one (21), eligible for the Louisiana Medicaid Program who are listed on OCDD's Request for Services Registry who are Chisholm Class Members.

2.3.2.2 Voluntary MCO Populations may elect to receive all Medicaid Covered Services through the Managed Care Program at any time, effective the earliest possible month that the administrative action can be taken.

2.3.2.3 Voluntary MCO Populations may return to FFS for all Medicaid Covered Services other than ABA, SBHS, and NEMT/NEAT services at any time, effective the earliest possible month that the administrative action can be taken.

2.3.2.4 Voluntary MCO Populations who have previously returned to FFS for all Medicaid Covered Services other than SBHS and NEMT/NEAT services may elect to return to the Managed Care Program for all Medicaid Covered Services at any time, effective the earliest possible month that the administrative action can be taken**.**

2.3.3 Mandatory MCO Populations for ABA, SBHS, and NEAT Services Only

The Contractor shall accept Enrollment of the following Louisiana Medicaid Program populations and provide for ABA, SBHS, and NEAT to all Medicaid Covered ~~s~~Services only, and receive all other Medicaid Covered Services through FFS:

2.3.3.1 Beneficiaries residing in Nursing Facilities (NF); and

2.3.3.2 Beneficiaries under the age of twenty-one (21) residing in ICF/IIDs.

2.3.4 Mandatory MCO Populations for ABA, SBHS, and NEMT/NEAT Services Only

The Contractor shall accept Enrollment of the following Louisiana Medicaid Program populations and provide for ABA, SBHS, and NEMT/NEAT to all Medicaid Covered ~~s~~Services only, and receive all other Medicaid Covered Services through FFS:

2.3.4.1 Beneficiaries who are enrolled in both the Louisiana Medicaid Program and Medicare (Medicaid dual eligible), except those residing in an institution as specified in this section.

2.3.4.2 LaHIPP Beneficiaries except those residing in an institution as specified in this section.

2.3.5 Mandatory MCO Populations for All MCO Covered Services Except SBHS and CSoC Services

The Contractor shall accept Enrollment of children who are functionally eligible and participate in the CSoC program for all services as specified in the Services section, except SBHS and CSoC services. For this population, Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (TGH), and SUD Residential services remain the responsibility of the Contractor. The Contractor shall implement procedures to coordinate services it provides to the Enrollee with the services the Enrollee receives from the CSoC contractor, including sharing the results of any identification and assessment of that Enrollee's needs to prevent duplication of those activities as required by 42 CFR §438.208(b)(4).

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2.3.6 Excluded Populations

The following Louisiana Medicaid Program populations cannot participate in the Managed Care Program and receive all Medicaid Covered Services through FFS:

2.3.6.1 Beneficiaries age twenty-one (21) and older residing in an ICF/IID;

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

2.3.6.3 Refugee Cash Assistance;

2.3.6.4 Refugee Medical Assistance;

2.3.6.5 Take Charge Plus;

2.3.6.6 Specified Low Income Medicare Beneficiary (SLMB) only;

2.3.6.7 Qualified Individual Category 1 (QI-1);

2.3.6.8 Qualified Disabled Working Individual (QDWI);

2.3.6.9 Qualified Medicaid Beneficiary (QMB) only;

2.3.6.10 Beneficiaries with a limited eligibility period including:

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

2.3.6.10.2 Emergency Services Only – Emergency Services for aliens who do not meet Medicaid citizenship/ five (5) year residency requirements.

2.3.7 Changes to Population Groups

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

2.3.8 Eligibility, Enrollment and Disenrollment

The Contractor shall abide by all Enrollment and Disenrollment procedures. Automatic Assignment algorithms and decisions regarding Enrollment are at the sole discretion of LDH, and the Contractor must abide by those decisions.

2.3.9 Voluntary Selection of MCO

2.3.9.1 Potential Enrollees shall be given an opportunity to choose an MCO at the time of application. Once the Potential Enrollee is determined eligible, their choice of MCO shall be transmitted to the Enrollment Broker.

2.3.9.2 During the ninety (90) Calendar Days following the date of the Enrollee's initial Enrollment into an MCO, or during the ninety (90) Calendar Days following the date the State or its designee sends the Enrollee notice of that Enrollment, whichever is later, the Enrollee shall be allowed to request Disenrollment without cause by submitting an oral or written request to the Enrollment Broker.

2.3.9.3 All eligible Enrollees shall be provided the opportunity to request Disenrollment without cause at least once every twelve (12) months thereafter.

2.3.9.4 Enrollees whose effective dates of Enrollment are prior to the Operational Start Date shall be given an opportunity to choose an MCO at the start of the Contract through a special Disenrollment period.

2.3.10 Assistance with Medicaid Eligibility Renewal

Renewals of Louisiana Medicaid Program eligibility are conducted annually. At least thirty (30) Calendar Days prior to the renewal date as indicated on the ASC X12N 834 Benefit Enrollment and Maintenance electronic transaction file, the Contractor shall provide assistance to Enrollees with eligibility renewals. The Contractor shall attempt to contact the Enrollee by mail and/or phone three (3) times to encourage their Timely response to the renewal. The Enrollee should be provided with information on the ways to apply / renew.

2.3.10.1 The Contractor may reach out to former Enrollees of their managed care plan, who have been disenrolled by the State due to the loss of Medicaid eligibility, up to sixty (60) calendar days post disenrollment, to assist them in enrolling in health coverage, provided it does not violate applicable marketing rules prohibiting discrimination.

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2.3.11 Suspension of and/or Limits on Enrollments

2.3.11.1 The Contractor shall notify LDH of the maximum number of Enrollees it is able to enroll and maintain under the Contract prior to the initial Enrollment and upon request.

2.3.11.2 In LDH's sole discretion, additional Enrollees may not be assigned to the Contractor through the Automatic Assignment process once the Contractor reaches its Capacity. LDH also has the sole discretion to suspend the Contractor's Automatic Assignment due to Contract noncompliance, as further explained in the *Automatic Assignment* section.

2.3.11.3 Additional Enrollees may be assigned to the Contractor as a result of: Enrollee choice and newborn Enrollments; automatic reenrollments when an Enrollee loses and regains eligibility within sixty (60) Calendar Days; the need to ensure continuity of care for the Enrollee; or determination of just cause by LDH.

2.3.12 Contractor Enrollment Procedures

2.3.12.1 Acceptance of All Enrollees

2.3.12.1.1 The Contractor shall enroll any Beneficiary in a Mandatory MCO Population or Voluntary MCO Population who selects it or is otherwise assigned to it.

2.3.12.1.2 The Contractor shall accept new Enrollment of Beneficiaries in the order in which they are submitted by the Enrollment Broker without restriction as specified by LDH, up to the limits set under the Contract with LDH [42 CFR §438.3(d)(1)]. Enrollment is voluntary, except in the case of Mandatory MCO Populations that meet the conditions set forth in 42 CFR §438.50(a).

2.3.12.1.3 The Contractor shall not discriminate against Enrollees on the basis of their health history, health status, need for health care services or adverse change in health status; or on the basis of age, religious belief, sex, gender, sexual orientation, or disability. Further, the Contractor shall not use any policy or practice that has the effect of discriminating on the basis of age, religious belief, race, color, national origin, sex, sexual orientation, or disability. This applies

to Enrollment, reenrollment or Disenrollment from the Contractor. The Contractor shall be subject to Monetary Penalties and other sanctions if it is determined by LDH that the Contractor has requested Disenrollment for any of these prohibited reasons.

2.3.12.1.4 The Contractor shall comply with all Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, and applicable Waivers governing direct reimbursement to Enrollees for payments made by them for MCO Covered Services and supplies delivered during a period of retroactive eligibility.

2.3.12.2 Effective Date of Enrollment

2.3.12.2.1 The effective date of initial Enrollment with the Contractor shall be the date provided on the outbound ASC X12N 834 Benefit Enrollment and Maintenance electronic transaction file initiated by the Enrollment Broker.

2.3.12.2.2 An Enrollee's effective date of Enrollment with the Contractor shall be the same as the Enrollee's effective date of eligibility for the Louisiana Medicaid Program, subject to the following limitations:

2.3.12.2.2.1 Beneficiaries may be retroactively approved for the Louisiana Medicaid Program. Beneficiaries retroactively approved for the Louisiana Medicaid Program may be retroactively enrolled with the Contractor for a period of up to twelve (12) months.

2.3.12.2.2.2 In cases of retroactive Enrollment, the effective date of Enrollment may occur prior to either the Beneficiary or the Contractor being notified of the Enrollment.

2.3.12.2.3 The Contractor shall not be liable for the cost of any MCO Covered Services rendered prior to the effective date of Enrollment. However, the Contractor shall be responsible for the costs of MCO Covered Services rendered on or after 12:01 a.m. on the effective date of Enrollment, including reimbursement to an Enrollee for payments already made by the Enrollee for MCO Covered Services rendered during the retroactive Enrollment period in accordance with the process outlined in the **MCO Manual**.

2.3.12.2.4 LDH shall make monthly Capitation Payments to the Contractor from the effective date of an Enrollee's Enrollment. LDH shall deduct from the monthly Capitation Payment any FFS Claims paid for services rendered during the retroactive Enrollment period.

2.3.12.2.5 Except for cost sharing that does not exceed the cost sharing amounts in the State Plan, the Contractor shall ensure that Enrollees are held harmless for the cost of MCO Covered Services provided as of the effective date of Enrollment with the Contractor.

2.3.12.3 Changes in Demographic Information or Status

2.3.12.3.1 The Contractor shall report to LDH, in the manner and format determined by LDH, any changes in demographic information or living arrangements for families or individual Enrollees within five (5) Business Days of discovery, including changes in mailing address, residential address, e-mail address, and telephone number.

2.3.12.3.2 The Contractor shall submit notifications to LDH, in the manner and format determined by LDH in writing, any other known changes in status which may affect eligibility for participation in the Managed Care Program including, but not limited to, death, admission to an ICF/IID for Enrollees age twenty-one (21) and older, and entry into involuntary custody/incarceration.

2.3.12.4 Newborn Enrollment

2.3.12.4.1 The Contractor shall contact Enrollees who are expectant mothers at least sixty (60) Calendar Days prior to the expected date of delivery to encourage the mothers to choose a PCP for their newborns. In the event that the pregnant Enrollee does not select a PCP, the Contractor shall provide the Enrollee with a minimum of fourteen (14) Calendar Days after birth to select a PCP prior to assigning one.

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

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

2.3.12.4.3.1 Disenroll the newborn from the MCO in which the newborn was incorrectly enrolled effective the last Calendar Day of the month of discovery, unless an MCO choice separate from the mother's MCO is on record;

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2.3.12.4.3.2 Enroll the newborn in the correct MCO effective the first Calendar Day of the month following discovery, unless a MCO choice separate from the mother's MCO is on record;

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

2.3.12.4.3.4 Make payments only to the MCO in which the newborn is correctly enrolled for the period of coverage.

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

2.3.12.4.5 The MCO in which the newborn is correctly enrolled shall be responsible for the coverage of, and payment for, MCO Covered Services provided to the newborn for the full period of coverage. LDH shall be liable only for the Capitation Payment to the MCO in which the newborn is enrolled.

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

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

2.3.12.5 Justice-Involved Enrollees

All justice-involved Enrollees releasing from incarceration shall be enrolled in accordance with the process outlined in the **Justice-Involved Pre-Release Enrollment Program Manual**.

2.3.13 Disenrollment

2.3.13.1 General Requirements

2.3.13.1.1 The Contractor shall, at a minimum, continue to provide MCO Covered Services and all other services required under this Contract to Enrollees up to 12:00 a.m. on the Calendar Day after the effective date of Disenrollment.

2.3.13.1.2 The Contractor should demonstrate a satisfactorily low Voluntary Disenrollment Rate as compared with other MCOs, as determined by LDH.

2.3.13.2 Voluntary Disenrollment Requested by the Enrollee

An Enrollee may request Disenrollment from the Contractor as follows:

2.3.13.2.1 **For cause**, at any time. The following circumstances are cause for Disenrollment:

- The Contractor does not, because of moral or religious objections, cover the service the Enrollee seeks;
- The Enrollee needs related services to be performed at the same time; not all related services are available within the Enrollee's MCO and the Enrollee's PCP or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;
- The Contract between the Contractor and LDH is terminated;
- Poor quality of care by the Contractor as determined by LDH;
- Lack of access to MCO Covered Services as determined by LDH;
- The Enrollee's active specialized behavioral health provider ceases to contract with the Contractor for reasons other than non-compliance with the Network Provider Agreement or this Contract; or
- Any other reason deemed to be valid by LDH and/or its agent.

2.3.13.2.2 **Without cause** at the following times:

- During the Disenrollment period offered to Enrollees at the start of the Contract;
- During the ninety (90) Calendar Days following the date of the Enrollee's initial Enrollment with the Contractor or during the ninety (90) Calendar Days following the date the Enrollment Broker sends the Enrollee notice of that Enrollment, whichever is later;
- During the Enrollment Period;
- Upon automatic reenrollment under 42 CFR §438.56(g), if a temporary (ninety (90) Calendar Day) loss of Louisiana Medicaid Program eligibility has caused the Enrollee to miss the Enrollment Period;
- When LDH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a)(3); or
- After LDH notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722.

2.3.13.3 Involuntary Disenrollment Requested by the Contractor

2.3.13.3.1 The Contractor may request involuntary Disenrollment of an Enrollee if the Enrollee's utilization of services constitutes Fraud, Waste, and/or Abuse such as misusing or loaning the Enrollee's MCO Member ID Card to another person to obtain services. In such case, the Contractor shall report the event to LDH and MFCU.

2.3.13.3.2 The Contractor shall submit Disenrollment requests to the Enrollment Broker, in a format and manner to be determined by LDH.

2.3.13.3.3 The Contractor shall ensure that involuntary Disenrollment documents are maintained in an identifiable Enrollee record.

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

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

2.3.13.3.6 All Disenrollment requests shall be reviewed on a case-by-case basis and are subject to the sole discretion of LDH or its designee (Enrollment Broker). All decisions are final and not subject to the dispute resolution process by the Contractor.

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

2.3.13.3.7.1 The reason for the Disenrollment;

2.3.13.3.7.2 The effective date of the Disenrollment; and

2.3.13.3.7.3 An instruction that the Enrollee choose a new MCO.

2.3.13.3.8 Until the Enrollee is Disenrolled by the Enrollment Broker, the Contractor shall continue to be responsible for the provision of all MCO Covered Services to the Enrollee.

2.3.13.4 Disenrollment Effective Date

2.3.13.4.1 The effective date of Disenrollment shall be no later than the first (1st) Calendar Day of the second (2nd) month following the calendar month in which the request for Disenrollment is filed.

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2.3.13.4.2 If LDH or its designee fails to make a Disenrollment determination by the first (1st) Calendar Day of the second (2nd) month following the month in which the request for Disenrollment is filed, the Disenrollment is deemed approved.

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2.3.13.4.3 LDH, the Contractor, and the Enrollment Broker shall reconcile Enrollment/Disenrollment issues at the end of each month utilizing an agreed upon procedure.

2.3.14 Enrollment and Disenrollment Updates

2.3.14.1 LDH's Enrollment Broker shall notify the Contractor at specified times each month of the Beneficiaries that are enrolled, reenrolled, or disenrolled from the Contractor for the following month. The Contractor shall receive this notification through the ASC X12N 834 Benefit Enrollment and Maintenance electronic transaction file, or in instances of corrections to closed segments or other special circumstances, the Contractor shall receive this notification through a manual correction processing file.

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

2.3.15 Updates

The Enrollment Broker shall make available to the Contractor daily via electronic media (ASC X12N 834 Benefit Enrollment and Maintenance electronic transaction file) updates on Beneficiaries newly enrolled with the Contractor in the format specified in the **MCO System Companion Guide**. The Contractor shall have written policies and procedures for receiving these updates, incorporating them into its management information system and ensuring this information is available to their providers. Policies and procedures shall be available during Readiness Review.

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

LDH reserves the right to require the Contractor to accept real-time Enrollment updates from the Enrollment Broker upon the implementation of such functionality by the Enrollment Broker.

2.3.16 Reconciliation

2.3.16.1 Enrollment

The Contractor is responsible for monthly and quarterly reconciliation of the membership list of Enrollments and Disenrollments received from the Enrollment Broker against its internal records. The Contractor shall provide written notification to the Enrollment Broker of any data inconsistencies within ten (10) Calendar Days of receipt of the monthly and quarterly reconciliation data file.

2.3.16.2 Payment

The Contractor shall receive a monthly electronic file (ASC X12N 820 Transaction) from the Fiscal Intermediary (FI) listing all Enrollees for whom the Contractor received a Capitation Payment and the amount received. The Contractor is responsible for reconciling this listing against its internal records. It is the Contractor's responsibility to notify the FI of any discrepancies within sixty (60) Calendar Days of the file date. Lack of compliance with reconciliation requirements shall result in the deduction of a portion of future monthly payments and/or Monetary Penalties as defined in Attachment G, *Table of Monetary Penalties* until requirements are met.

2.4 Services

2.4.1 MCO Covered Services

2.4.1.1 The Contractor shall provide Enrollees all medically necessary MCO Covered Services specified in Attachment B, *MCO Covered Services*, as those

services are defined in the State Plan and the **MCO Manual**. The Contractor shall possess the expertise and resources to ensure the delivery of quality healthcare services to its Enrollees in accordance with this Contract and prevailing medical community and national standards.

2.4.1.2 MCO Covered Services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Beneficiaries under FFS, as set forth in 42 CFR §440.230, and for Enrollees under the age of twenty-one (21), as set forth in 42 CFR Part 441, Subpart B. [42 CFR §438.210(a)(2)].

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

2.4.1.4 In accordance with 42 CFR §438.210(a)(4), the Contractor may place appropriate limits on a service that are:

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

2.4.1.4.2 For the purpose of utilization control, provided that:

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

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

2.4.1.4.2.3 Family planning services are provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.

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

2.4.1.5.1 A public health quarantine or isolation order or recommendation also establishes medical necessity of healthcare services.

2.4.1.6 The Contractor shall cover medically necessary services that address:

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

2.4.1.6.2 The ability for an Enrollee to achieve age-appropriate growth and development; and

2.4.1.6.3 The ability for an Enrollee to attain, maintain, or regain functional capacity.

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

2.4.1.8 The Contractor shall not avoid costs for services covered in its Contract by referring Enrollees to publicly supported health care resources. [42 CFR §457.1201(p)]

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

2.4.1.10 The Contractor shall not condition the provision of care or otherwise discriminate against an Enrollee based on whether or not the Enrollee has executed an Advance Directive. [42 CFR §438.3(j)(1) and (2); 42 CFR §489.102(a)(3).]

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

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

2.4.1.12.1 In such event, the charges to the Contractor shall be obtained by LDH in the form of deductions from the next monthly Capitation Payment made to the Contractor or a future payment as determined by LDH. With such deductions, LDH shall provide a list of the Enrollees for whom payments were deducted, the nature of the service(s) denied, and payments LDH made or will make to provide the medically necessary MCO Covered Services.

2.4.1.12.2 In addition to the deduction, the Contractor may be assessed a Monetary Penalty per incident of non-compliance (see Attachment G, *Table of Monetary Penalties*).

2.4.2 Excluded Services

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

2.4.2.1.1 Adult dental services with the exception of surgical dental services and Emergency Dental Services;

2.4.2.1.2 Services to individuals in ICF/IIDs;

2.4.2.1.3 Personal care services for those ages twenty-one (21) and older;

2.4.2.1.4 Nursing facility services, with the exception of post-acute rehabilitative care provided at the discretion of the Contractor when it is cost effective to do so in place of continued inpatient care as an approved In Lieu of Service;

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

2.4.2.1.6 All home & community-based Waiver services;

2.4.2.1.7 Targeted case management services;

2.4.2.1.8 Services provided through LDH's EarlySteps Program; and

2.4.2.1.9 The following excluded drugs:

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

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

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

2.4.2.1.9.4 Drug Efficacy Study Implementation (DESI) drugs; and

2.4.2.1.9.5 Select nonprescription drugs, not including OTC antihistamines, antihistamine/decongestant combinations, or polyethylene glycol.

2.4.3 Prohibited Services

The following services are not Medicaid Covered Services and shall not be provided to Enrollees under this Contract:

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

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

2.4.3.3 Elective cosmetic surgery; and

2.4.3.4 Assisted reproductive technology for treatment of infertility.

2.4.4 In Lieu of Services

2.4.4.1 The Contractor may, at its option, cover services or settings for Enrollees that are in lieu of MCO Covered Services if the following conditions are met, as required in 42 CFR §438.3(e)(2)(i)-(iii):

2.4.4.1.1 LDH determines that the alternative service or setting is a medically appropriate and cost effective substitute for the MCO Covered Service or setting under the State Plan;

2.4.4.1.2 The Enrollee is not required by the Contractor to use the alternative service or setting; and

2.4.4.1.3 The approved In Lieu of Services are authorized and identified in Attachment C, *In Lieu of Services*. Additional guidance and service policies are provided in the **MCO Manual.**

2.4.4.2 The utilization and actual cost of In Lieu of Services is taken into account in developing the component of the Capitation Rates that represents the MCO Covered Services, unless a statute or regulation explicitly requires otherwise.

2.4.4.3 The Contractor shall submit all In Lieu of Services for LDH approval in accordance with the **MCO Manual**.

2.4.4.4 The Contractor shall have a plan for identifying and reporting the utilization of In Lieu of Services to LDH in accordance with the **MCO Manual**. The plan shall be submitted to LDH or its designee during Readiness Review and upon any subsequent LDH approval of additional In Lieu of Services.

2.4.4.5 The Contractor shall utilize a consistent process to ensure that its licensed clinical staff or Network Provider uses their professional judgement to determine and document that the In Lieu of Service is medically appropriate for the specific Enrollee, based on the clinically oriented target population.

2.4.4.6 The Contractor shall identify In Lieu of Services in Encounter Data in accordance with the MCE System Companion Guide.

2.4.5 Value-Added Benefits

2.4.5.1 As permitted under 42 CFR §438.3(e)(1), the Contractor may offer Value-Added Benefits (VAB) which are not Medicaid Covered Services or prohibited services. VABs are provided at the Contractor's expense, are not included in the Capitation Rate, and shall be identified as VABs in Encounter Data in accordance with the **MCO Manual** and the **MCO System Companion Guide**.

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

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

2.4.5.4 The Contractor may propose to add to or expand upon the VAB(s) proposed in the Contractor's RFP response as pre-approved in writing by LDH. Deletions or reductions to the VAB(s) may be proposed on an annual basis and shall be submitted to LDH for approval by October 1 of each calender year to be effective January 1 of the following year. The Contractor may also propose adding new VABs on a quarterly basis. The Contractor shall submit requests in accordance with the **MCO Manual**.

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

2.4.5.5.1 Indicate the PMPM actuarial value of the VAB(s), individually and in aggregate, based on Enrollment projections for the Contractor's plan, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information; and

2.4.5.5.2 Include a statement of commitment to provide the VAB(s) for the year.

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

2.4.5.7 The proposed monetary value of the VAB(s) shall be considered a binding Contract deliverable. If for any reason, including, but not limited to, lack of Enrollee participation, the aggregated annual PMPM proposed is not expended by the Contractor, LDH reserves the right to require the

Contractor to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended.

2.4.5.8 VABs are not subject to Appeal and State Fair Hearing rights. A denial of these benefits shall not be considered an Adverse Benefit Determination for purposes of Enrollee Grievances and Appeals. The Contractor shall send the Enrollee a notification letter if a VAB is not approved.

2.4.6 Moral or Religious Objections

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

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

2.4.6.1.2 Potential Enrollees before and during Enrollment with the Contractor;

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

2.4.6.1.4 Enrollees through the inclusion of the information in the Member Handbook.

2.4.6.2 If the Contractor elects not to provide, reimburse for, or provide coverage of an MCO Covered Service described in this section because of an objection on moral or religious grounds, the Contractor's monthly Capitation Payment will be adjusted accordingly.

2.5 Population Health and Social Determinants of Health

The Contractor shall participate in and support LDH's efforts to advance population health.

2.5.1 The Contractor shall develop a Population Health Strategic Plan aligned with the Louisiana Medicaid Managed Care Quality Strategy and submit it to LDH or its designee during Readiness Review and annually thereafter. The population health strategy shall include:

2.5.1.1 Prevention and wellness programs available to all Enrollees;

2.5.1.2 Prevention and wellness programs targeted to the following specific issues:

2.5.1.2.1 Reduction of key communicable diseases: HIV, HCV, and sexually transmitted infections;

2.5.1.2.2 Maternal mortality and morbidity;

2.5.1.2.3 Substance use disorders such as opioid use disorder;

2.5.1.2.4 Mental health conditions such as depression and anxiety;

2.5.1.2.5 Diabetes mellitus;

2.5.1.2.6 Hypertension;

2.5.1.2.7 Cardiovascular disease;

2.5.1.2.8 Tobacco cessation;

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2.5.1.2.9 Early childhood health and development, including Adverse Childhood Experiences (ACEs);

2.5.1.2.10 Obsesity management;

2.5.1.2.11 Asthma;

2.5.1.2.12 COPD;

2.5.1.2.13 Sickle Cell Disease; and

2.5.1.2.14 Cancer, to include, but not limited to Breast Cancer, Cervical Cancer, Colorectal Cancer, Lung Cancer and Other Cancer types.

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2.5.1.3 Plan to address priority social determinants of health (SDOH), which include housing, food insecurity, physical safety, and transportation;

2.5.1.4 Plan for identification of Enrollees that could benefit from prevention and wellness programs through several mechanisms, which shall include, but not be limited to:

2.5.1.4.1 Health Needs Assessments;

2.5.1.4.2 Claims analysis and risk scoring;

2.5.1.4.3 Provider referral; and,

2.5.1.4.4 Enrollee self-referral.

2.5.1.5 Initiatives to increase Enrollee and Network Provider awareness of Contractor's population health programs;

2.5.1.6 Collaboration with community-based organizations to facilitate the provision of services to Enrollees;

2.5.1.7 Referral to Office of Public Health programs as appropriate including, but not limited to, the following: Women, Infants, and Children (WIC), Maternal, Infant, Early Childhood Home Visiting family coaching and support services, the Louisiana Early Hearing Detection and Intervention

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

2.5.1.8 Referral to OCDD Waiver services and EarlySteps;

2.5.1.9 Referral to services under the Office of Behavioral Health;

2.5.1.10 Description of how the care management program will serve to advance population health goals; and

2.5.1.11 Description of how the Health Equity Plan as described in the *Health Equity* section is incorporated into the population health strategy.

2.5.2 The Contractor shall provide an annual report to LDH, and as requested by LDH, on its Population Health Strategic Plan implementation.

2.5.3 Collaborative Work on Population Health Initiatives

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

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

2.5.4 CMS Cell and Gene Therapy Model

2.5.4.1 The MCO shall follow all requirements of the CMS Cell and Gene Therapy Model identified by LDH. Certain high-cost drugs provided in an inpatient hospital setting will be reimbursed separately from the per diem payment, or cost-based reimbursement. The hospital may submit a separate outpatient hospital claim to receive reimbursement for certain high-cost drugs during a time of inpatient services. Providers must be paid no less than the actual acquisition cost of the drug(s). The actual acquisition cost shall be

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determined by an invoice or the cost substantiated by the wholesaler or manufacturer. The list of high-cost drugs is maintained by LDH.

2.6 Health Equity

The Contractor must participate in, and support, LDH's efforts to reduce health disparities, address social risk factors, and achieve health equity. The Contractor must engage a variety of Enrollees and populations to develop and implement a Health Equity Plan designed to address the cultural, socioeconomic, racial, and regional disparities in health care that exist among the Contractor's Enrollees and communities within the State. The Health Equity Plan shall be developed in alignment with the Contractor's Population Health Strategic Plan, the Louisiana Medicaid Managed Care Quality Strategy, and the LDH Health Equity Plan.

2.6.1 The Contractor's Health Equity Plan shall be composed of three main sections, as follows:

2.6.1.1 Narrative of the Health Equity Plan development process, including meaningful community engagement;

2.6.1.2 Action plan consisting of focus areas, goals within each focus area, specific measurable objectives within each goal that define metrics and timelines that indicate success, and mechanisms to close the referral loop to act on identified social risk factors. Overall strategies and specific activities to achieve each measurable objective must include, but are not limited to:

2.6.1.2.1 Ensuring the delivery of services in a culturally appropriate and effective manner to all Enrollees by promoting cultural humility at all levels of the Contractor's organization and with Network Providers, including promoting awareness of implicit biases and how they impact policy and processes;

2.6.1.2.2 Engaging diverse families when designing services and interventions that integrate care and address childhood adversity and trauma;

2.6.1.2.3 Obtaining ongoing input from Enrollees who have disparate outcomes to incorporate the perspective of the Enrollee;

2.6.1.2.4 Ensuring that each functional area with outward facing communications tests potential publications with Enrollees for understanding and conveyance of the intended message, as well as cultural appropriateness;

2.6.1.2.5 Partnering with community-based organizations to address SDOH-related needs, including ensuring the active referral to and follow-up on identified needs related to SDOH by:

2.6.1.2.5.1 Providing validated up-to-date community resource lists for Enrollee and provider use;

2.6.1.2.5.2 Sharing health needs assessments and other sources identifying SDOH needs, subject to State and Federal privacy requirements, with Network Providers and community health workers, by request; and

2.6.1.2.5.3 Reimbursing Network Providers for screening for SDOH needs and submitting applicable diagnosis codes ("Z codes") on Claims including specific reimbursement amounts and frequencies.

2.6.1.3 Plan to conduct cultural responsiveness and implicit bias training within the Contractor's organization and among Network Providers.

2.6.2 Health Equity Plan Timeline

2.6.2.1 The Contractor shall submit its Health Equity Plan to LDH or its designee as part of Readiness Review.

2.6.2.2 The Contractor shall provide updates to LDH on implementation of its Health Equity Plan in an annual report of its progress on meeting Health Equity Plan objectives in the prior calendar year.

2.6.3 Transparency of MCO Performance on LDH Incentive-based Measures:

2.6.3.1 The Contractor shall ensure that data collection, data systems, and analysis allow for the identification of disparities by Enrollee characteristics. As directed by LDH, the Contractor shall stratify and annually report on quality measures by race, ethnicity, language, geographic location (urban/rural parish) and/or by disability in a format provided by LDH.

2.6.3.2 LDH may publicly share these stratified results, including comparing performance across MCOs, over time, and to State and other available benchmarks.

2.7 Case Management

2.7.1 Comprehensive Case Management Program

The Contractor shall offer a comprehensive case management program to support Enrollees, regardless of age, based on qualifying criteria and/or an individualized assessment of care needs. At a minimum, case management shall include both the populations and functions described below. When appropriate, the state contract shall supersede NCQA requirements related to the provision of case management services to enrollees.

2.7.2 Case Management Assessment

2.7.2.1 The Contractor shall use Claims data and other available data to identify Enrollees who meet the SHCN criteria on at least a monthly basis. The Contractor shall implement mechanisms to provide each Enrollee identified as having SHCN with a comprehensive Case Management assessment conducted by a qualified healthcare professional to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring.

Deleted: <#>MCO Performance Withhold Linked to Health Equity¶
<#>LDH may designate certain health equity related tasks and/or benchmarks to be linked to a portion of the MCO performance withhold consistent with the withhold requirements in Part 4 of the Contract.

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<#>The Contractor shall attempt to conduct Enrollee Health Needs Assessments (HNA) as part of the Enrollee welcome call to identify health and functional needs of Enrollees, and to identify Enrollees who require short-term care coordination or Case Management for medical, behavioral or social needs. When an Enrollee is a child, the HNA shall be completed by the Enrollee's parent or legal guardian.¶
<#>The Contractor shall develop, implement, and maintain procedures for completing an initial HNA for each Enrollee, and shall make best efforts to complete such screening within ninety (90) Calendar Days of the Enrollee's effective date of Enrollment [42 CFR §438.208(b)]. If the initial HNA attempt is unsuccessful, the Contractor shall attempt to conduct, and document its efforts to conduct, the HNA on at least three (3) different occasions, at different times of the day and on different days of the week. ¶
<#>The Contractor shall provide HNA data to the Enrollee's assigned PCP, and to LDH as requested.¶
<#>The Contractor's HNA shall:¶
<#>Utilize a common survey-based instrument, which shall be developed by LDH as described in Part 3: State Responsibilities;¶
<#>Be made available to Enrollees in multiple formats including web-based, print, and telephone;¶
<#>Be conducted with the consent of the Enrollee;¶
<#>Identify individuals for referral to Case Management; ¶
<#>Screen for needs relevant to priority social determinants of health as described in the *Population Health and Social Determinants of Health* section; and¶
<#>Include disclosures of how information will be used.

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2.7.2.2 The Contractor shall implement mechanisms to provide other Enrollees referred to Case Management with a comprehensive Case Management assessment to identify any needs or conditions of the Enrollee that require intervention by the Contractor, a course of treatment, or regular care monitoring.

2.7.2.3 The Contractor shall use a common comprehensive case management assessment tool approved by LDH.

2.7.2.4 The comprehensive case management assessment shall supersede the Health Needs Assessment (HNA) for members who are enrolled in Case Management and do not have an HNA on file.

2.7.2.5 The Contractor shall complete the required case management assessment for at least ninety percent (90%) of those Enrollees that the Contractor is able to contact and are willing to engage within sixty (60) Calendar Days of being identified as having SHCN or of being referred to Case Management.

2.7.2.6 The Contractor shall attempt to contact all Enrollees with SHCN to engage them in the Case Management program. The MCO may use any combination of telephonic, in-person, virtual, digital (including text and email), or traditional mail options based on the individuals' needs and preferences to outreach and engage in all case management-related activities to include but not be limited to completion of the comprehensive assessment/reassessment, plan of care development/updates, follow up, and multidisciplinary team meetings.

2.7.3 Referral to Case Management

2.7.3.1 The Contractor shall receive referrals to Case Management through the HNA, identification of individuals with SHCN, as well as referral sources, including, but not limited to:

2.7.3.1.1 Enrollee services and self-referral (including Enrollee Grievances);

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

2.7.3.1.3 State staff, including BHSF, OBH, OAAS, OCDD, OPH, and DCFS.

2.7.3.2 The Contractor shall provide guidelines on how and in what circumstances to refer Enrollees for potential engagement in Case Management in a manner and format that is readily accessible to providers.

2.7.3.3 The Contractor shall provide guidelines to Enrollees in the Member Handbook on how and in what circumstances Enrollees may engage in Case Management.

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2.7.3.4 The Contractor shall consider all referred Enrollees for engagement in Case Management.

2.7.4 Case Management Based on Need

The Contractor shall implement a Case Management program that provides for differing levels of Case Management based on an individual Enrollee's needs with respect to their preferences. The Contractor shall engage Enrollees, or their parent or legal guardian, as appropriate, in a level of Case Management commensurate with their care needs identified through SHCN designation or results from the Health Needs Assessment as described below. If requested by the Enrollee, or the Enrollee's parent or legal guardian, the frequency and/or method of engagement may be increased, reduced, or substituted or declined. The Contractor shall retain documentation of such requests. Where the Enrollee's PCP or behavioral health provider offers Case Management, the Contractor shall support the provider as the lead case manager on the multi-disciplinary care team.

The Contractor shall maintain two (2) levels of Case Management and Transitional Case Management for individuals as they move between care settings.

2.7.4.1 Case Management Program for High Risk Enrollees

Enrollees with SHCN enrolled in the case management program or those identifies as high-risk for the case management are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH.

2.7.4.1.1 The Contractor shall attempt to outreach, and document its efforts to outreach to engage the Enrollees on at least three (3) different occasions, at different times of the day, and on different days of the week within thirty (30) days of being identified for case management services.

2.7.4.1.2 Enrollees will be outreached for engagement in case management and will be offered the opportunity to complete a comprehensive Case Management assessment, which shall be initiated within thirty (30) days and completed within sixty (60) days of being identified for case management services.

2.7.4.1.3 A POC shall be completed within thirty (30) Calendar Days of the Case Management assessment being completed and shall include additional assessment of the home environment, as appropriate, and priority SDOH needs (see *Population Health and Social Determinants of Health* section).

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2.7.4.1.4 The POC shall be made available to the Enrollee's PCP electronically or in other formats as needed or requested.

2.7.4.1.5 Case Management contact will occur at a minimum monthly, but may occur more as needed. Less frequent contact is allowed when based on Enrollee preferences.

2.7.4.1.6 Case Management mulit-diciplinary team meetings shall occur at least quarterly, or as indicated based on Enrollee preferences within the Enrollee's POC, or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i).

2.7.4.1.7 POC updates will occur at a minimum of every thrity (30) days with successful member outreach.

2.7.4.1.8 Formal re-assessment will occur at a minimum of every ninety (90) days.

2.7.4.1.9 Case Management may integrate community health worker support.

2.7.4.1.10 Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs.

2.7.4.2 Case Management for Rising Risk/Low Risk

Enrollees engaged in this program of Case Management typically require support in care coordination and in addressing SDOH.

2.7.4.2.1 A Comprehensive Case Management assessment shall be initiated within 30 days and completed within sixty (60) days of being identified for case management services. The Contractor shall attempt to outreach, and document its efforts to outreach to engage the Enrollees on at least three (3) different occasions, at different times of the day, and on different days of the week within thirty (30) days of the initial outreach attempt.

2.7.4.2.2 A POC shall be completed within - sixty (60) Calendar Days of the Comprehensive Case Management assessment being completed and shall include additional assessment of the home environment, as appropriate, and priority SDOH needs (see *Population Health and Social Determinants of Health* section).

2.7.4.2.3 The POC shall be made available to the Enrollee's PCP electronically as needed or requested.

2.7.4.2.4 Case Management contact will occur at a minimum of quarterly or as needed based on Enrolle preferences.

2.7.4.2.5 Case Management multi-disciplinary meetings shall occur as needed to coordinate the services identified in the POC with the Enrollee between settings of care, including appropriate

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<#>Enrollees engaged in the medium level of Case Management are typically of rising risk and need focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within thirty (30) Calendar Days of Case Management assessment being completed and include assessment of the home environment and priority SDOH (see *Population Health and Social Determinants of Health* section). Case Management meetings shall occur at least monthly, with quarterly updates to the POC, or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i), and formal in-person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of quarterly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 2 Enrollees shall focus on implementation of the ...

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discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i).

2.7.4.2.6 POC updates will occur quarterly.

2.7.4.3 Transitional Case Management

The Contractor shall implement procedures ~~to~~ that allow for collaboration with providers and the coordination of services for Enrollees transitioning between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i). The Contractor shall provide Transitional Case Management for Enrollees not enrolled in Case Management with the following high-risk diagnoses:

- Sepsis
- Stroke
- Congestive Heart Failure
- Coronary Artery Disease
- Cardiac Arrhythmias
- Chronic Obstructive Pulmonary Disease
- Diabetes Mellitus
- Spinal Stenosis
- Hip Fracture
- Peripheral Vascular Disease
- Deep Vein Thrombosis
- Pulmonary Embolism
- Schizophrenia
- Suicide/Self-harm
- Overdose
- Major Depressive Disorder:
- Schizoaffective Disorder
- Bi-Polar Disorder
- Substance Use Dependence Disorder
- And other behavioral health diagnoses in which a person may need assistance transitioning from one level of care to another.

Transitional Case Management supports transitions between institutional and community care settings, including, but not limited to, transitions to/from inpatient hospitals, nursing facilities (not including members of the DOJ Agreement Target Population).

Transitional Case Management shall be available for psychiatric residential treatment facilities (PRTFs), therapeutic group homes (TGHs), ICF/IIDs,

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residential substance use disorder treatment settings, incarceration and transitions to permanent supportive housing upon notification to the MCO.

Transitional Case Management shall include:

2.7.4.3.1 The Contractor shall support with transition between settings of care based on the members needs upon receipt of notification from the facility. This includes supporting facility discharge planning, through activities such as arranging post discharge appointments and linkages as appropriate, medication reconciliation review, patient education and self-management strategies, coordinating with provider facility's treatment team, Utilization Management and arranging post discharge appointments.

2.7.4.3.2 For Enrollees preparing for discharge from a PRTF, TGH, or ICF/IID, upon receipt of notification from the facility, the Contractor will support facilities in developing a discharge plan that includes aftercare service; which, the Contractor shall proactively coordinate with the provider facility's treatment team and the guardian to discuss ongoing treatment needs, including specialized services that may not be routinely available in standard step-down settings, a minimum of sixty (60) calendar days prior to anticipated discharge. The Contractor shall ensure that all needed outpatient behavioral health services have been identified and scheduled for the youth thirty (30) calendar days prior to anticipated discharge. If the recommended services will not be available to the member at the time of discharge, then the Contractor shall recommend, identify, and schedule alternative services that will meet the member's needs.

2.7.4.3.3 Follow up with Enrollees within seven (7) Calendar Days following discharge/transition notification date to ensure that services are being provided or scheduled as detailed within the Enrollee's Discharge Plan.

2.7.4.3.4 For Enrollees identified as homeless at the time of care transition, the care management team shall include a housing specialist on the multi-disciplinary care team. Housing specialists shall also be used to ensure Enrollees transitioning from facility to community are connected to appropriate housing resources.

2.7.5.3.5

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

The Contractor shall develop a specialized community Case Management program consistent with the DOJ Agreement and LDH-issued guidance for the target population transitioning or diverted from nursing facility level of care using subcontracted community case managers who meet the qualifications established by LDH. The Contractor shall make a referral to a community Case Management agency within one (1) Business Day of receipt of a referral from LDH. The Contractor shall maintain ultimate responsibility for ensuring the Case Management needs of the target population are met by community case managers and community case managers satisfactorily completing required activities.

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Deleted: Development of a transition POC in coordination with the care setting, the Enrollee, and other key members of an Enrollee's multi-disciplinary team prior to the transition which is provided in writing to the Enrollee upon discharge, includes post discharge care appointments and linkages as appropriate, medication reconciliation, patient education and self-management strategies, and addresses Prior Authorization needs. The Enrollee shall be provided the case manager's name and contact information prior to discharge.

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<#>Coordination across the multi-disciplinary team involved in Transitional Case Management for Enrollees.¶
<#>Follow up with Enrollees within seven (7) Calendar Days following discharge/transition to ensure that services are being provided as detailed within the Enrollee's transition POC. The POC shall identify circumstances in which the follow-up includes a face-to-face visit.

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Deleted: <#>Development of a transition POC in coordination with the care setting, the Enrollee, and other key members of an Enrollee's multi-disciplinary team prior to the transition which is provided in writing to the Enrollee upon discharge, includes post , which is provided in writing to the Enrollee upon discharge, includes post-discharge care appointments and linkages as appropriate, medication reconciliation, patient education and self-management strategies, and addresses Prior Authorization needs. The Enrollee shall be provided the case manager's name and contact information prior to discharge.

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Deleted: <#>For Enrollees identified as homeless at the time of care transition, the care management team shall include a housing specialist, as described in the Individual Plan of Care subsection, on the multi-disciplinary care team. Housing specialists shall also be used to ensure Enrollees transitioning from facility to community are connected to appropriate housing resources, including, but not limited to, referral of Potential Enrollees to Contractor's Permanent ...

In addition, the Contractor shall consider DOJ at-risk members as special health care needs population eligible for MCO case management. The Contractor shall identify members who meet the at-risk criteria and provide case management based on member needs and preferences.

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2.7.7 Independent Evaluations for PASRR Level II

2.7.7.1 The Contractor shall be responsible for conducting PASRR Level II evaluations of Enrollees, directly or through a Subcontractor, upon referral from LDH. PASRR Level II evaluations must be performed by a licensed mental health professional (LMHP). Referrals shall be based upon the need for an independent evaluation to determine the need for nursing facility services and/or the need for specialized services to address mental health issues before the Enrollee is in a nursing facility. This evaluation does not include individuals with a developmental disability (DD); there is a separate determination process outside of this Contract for DD evaluations.

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

2.7.7.3 Evaluators may use relevant evaluative data, obtained prior to initiation of PASRR, if the data are considered valid and accurate and reflect the current functional status of the individual. However, if necessary to supplement and verify the currency and accuracy of existing data, the evaluator shall gather additional information necessary to assess proper placement and treatment.

2.7.7.4 In order to comply with mandated timelines, the Contractor shall submit the completed Level II evaluation report to OBH within four (4) Calendar Days of receipt of the referral from OBH.

2.7.7.5 Level II evaluation recommendations shall focus on ensuring the least restrictive setting appropriate with the appropriate services.

2.7.7.6 When OBH determines that nursing facility services are not appropriate, the Contractor shall assist eligible Enrollees to obtain appropriate alternative behavioral health services available under this Contract.

2.7.7.7 If at any time the Contractor discovers that an Enrollee residing in a nursing home who has an SMI has not received a Level II determination, the Contractor shall notify OBH.

2.7.7.8 The Contractor shall track Enrollees in a nursing facility who have gone through the PASRR process, those identified with SMI and those receiving specialized services, as per 42 CFR §483.130.

2.7.7.9 The Contractor shall track and report quarterly to LDH the delivery of all PASRR SBHS as defined and required under 42 CFR §483.120 and the DOJ Agreement.

2.7.7.10 The Contractor shall report to LDH indicators relative to individual evaluations on a quarterly basis with information available by region, type of placements, results of recommendations, location of individuals and referral sources as outlined in the LDH-issued reporting template.

2.7.7.11 The Contractor and its Level II evaluators shall utilize technology and systems required by LDH for the transferring of information related to PASRR requests including submission of Level II evaluations and receipt of final determinations as outlined within the DOJ Compliance Guide.

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2.7.8 Individual Plan of Care

2.7.8.1 The Contractor shall develop a comprehensive individualized, person-centered POC for all Enrollees who are found eligible for Case Management. When an Enrollee receives services from the Contractor only for SBHS, the POC shall focus on coordination and integration, as appropriate. When an Enrollee receives services requiring a POC from LDH, such as Home and Community Based Waiver services or services through OPH, the Contractor shall collaborate with LDH or its designee in developing the POC.

2.7.8.2 Development of the POC shall be a person-centered process led by the Enrollee and their case manager with significant input from members of the Enrollee's multidisciplinary care team. When an Enrollee receives SBHS and has treatment plans developed through their behavioral health providers, the Contractor shall attempt to work with the Enrollee's behavioral health providers in order to incorporate the treatment plans into the Enrollee's overall POC and to support the Enrollee and the provider in their efforts to implement the treatment plan.

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

2.7.8.4 The POC shall be reviewed and revised upon reassessment of functional need. The POC revisions shall occur at least at the frequency required in the *Case Management Based on Need* section, or when the Enrollee's circumstances or needs change significantly, or at the request of the Enrollee, their parent or legal guardian, or a member of the multi-disciplinary care team.

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2.7.9 Multi-Disciplinary Care Team

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

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

2.7.9.3 In addition to the case manager and the Enrollee and their family or Authorized Representative, the care team may include members based on an Enrollee's specific care needs, preferences and goals identified in the POC. The team may change over time as the Enrollee's care needs change. Potential team members may include, but are not limited to:

2.7.9.3.1 Primary care provider;

2.7.9.3.2 Behavioral health providers;

2.7.9.3.3 Specialists;

2.7.9.3.4 Pharmacists;

2.7.9.3.5 Community health workers;

2.7.9.3.6 Home and community-based service providers and managers;

2.7.9.3.7 Housing specialists, if the Enrollee is identified as homeless; and

2.7.9.3.8 State staff, including transition coordinators.

2.7.9.4 MDT meetings will occur as needed based on the individual's care needs and preferences.

2.7.10 Case Management Policies and Procedures

The Contractor shall develop, implement, and maintain criteria and protocols for determining which Case Management activities may benefit an Enrollee. The Contractor shall submit such criteria and protocols to LDH or its designee as part of Readiness Review and prior to any substantive revisions. Where the Contractor delegates Case

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Deleted: When possible, the team shall meet in person but when necessary, team members may participate in meetings via telephone. At a minimum, multi-disciplinary care teams shall meet on a monthly basis for Enrollees in Tier 3 Case Management and on a quarterly basis for Enrollees in Tier 2 Case Management.

Management to a Network Provider, the Contractor shall have a written plan in place for monitoring and oversight of performance under any such agreements, including provisions for assessing Provider compliance and corrective actions and/or termination as appropriate.

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

2.7.10.1 Be subject to approval by LDH in writing;

2.7.10.2 Include procedures for contacting Enrollees to complete the Case Management comprehensive assessment, including number of contact attempts and methods of contact;

2.7.10.3 Include procedures for acquiring and documenting Enrollee opting in the Case Management program and/or consent (or the Enrollee's family or Authorized Representative) for the Contractor to share information about an Enrollee's care with Enrollee's providers to promote coordination and integration;

2.7.10.4 Include a plan describing how management of behavioral health services shall be integrated into the overall case management of the Enrollee population;

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

2.7.10.6 Include processes for the Contractor to measure the effectiveness and quality of the Contractor's Case Management procedures. Such processes shall include:

2.7.10.6.1 Tracking of frequency and type of Case Management contact;

2.7.10.6.2 Developing and implementing inclusion criteria for Case Management programs, including how the HNA and comprehensive assessment are utilized;

2.7.10.6.3 Determining expected outcomes in subgroups in different Case Management programs, including an impact analysis of Case Management on the use of the ED, inpatient admissions, and follow-up care;

2.7.10.6.4 Expected Case Management penetration and target rate of engagement;

2.7.10.6.5 Identification of relevant measurement processes or outcomes; and

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

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2.7.10.7 Include protocols for providing Case Management activities in a variety of settings, including, but not limited to an Enrollee's home, shelter, or other care setting;

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

2.7.10.9 Include criteria and protocols for discharging Enrollees from Case Management programs;

2.7.10.10 Ensure that the Case Management activities each Enrollee is receiving are appropriately documented;

2.7.10.11 Ensure regular contacts between Case Management staff, the Enrollee's PCP, the Enrollee's primary behavioral health provider as applicable, and the Enrollee; and

2.7.10.12 Include a process for graduation from all Case Management programs as an Enrollee's ongoing case management needs are reduced based on the Enrollee's POC.

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

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

2.7.12 Outreach Program for Pregnancy Services

The Contractor shall develop an outreach program to encourage women to seek prenatal services during the first trimester of pregnancy. This outreach program may utilize community and religious organizations and other community groups to develop outreach programs or referral networks, as well as include issuance of brochures and/or periodic articles emphasizing the importance of such care to all Enrollees.

2.7.13 Permanent Supportive Housing

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

2.7.13.2 For the PSH Program, the Contractor shall:

2.7.13.2.1 Assist potentially eligible Enrollees in completing the PSH Program application;

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<#>The HNA shall screen for problem gaming and tobacco usage. The case manager shall refer Enrollees who screen positive to appropriate Network Providers offering tobacco cessation treatment and/or problem gaming treatment services, including the Louisiana Tobacco Quitline.¶
<#>Information regarding treatment services and/or referral to care shall be entered into the Contractor's systems for the purpose of tracking and reporting according to various demographics. Tobacco cessation and problem gaming reports shall be made available upon LDH request in a format and frequency as determined by LDH.

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2.7.13.2.2 Within one (1) Business Day of receipt of a request from designated LDH PSH Program staff, provide accurate information about current and past Service Authorizations and Encounters for an Enrollee, particularly for behavioral health services such as Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), and Assertive Community Treatment (ACT);

2.7.13.2.3 Ensure Timely Prior Authorization for PSH tenancy and pre-tenancy supports as applicable;

2.7.13.2.4 Ensure PSH tenancy supports are delivered in a Timely and effective manner in accordance with an appropriate POC;

2.7.13.2.5 Respond Timely to service problems identified by PSH Program management, including, but not limited to, those that place an Enrollee's/tenant's housing or PSH services at risk; and

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

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

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

2.7.13.3.2 Assist with statewide targeted outreach to Enrollees/households who could benefit from PSH, including those Enrollees who are least likely to apply. The Contractor shall ensure participation of Contractor staff appropriate and sufficient for effective representation on LDH-convened PSH outreach committee(s); and

2.7.13.3.3 Develop for approval by LDH PSH Program staff written policies and procedures necessary to implement the PSH-related requirements of this Contract. Initial versions of PSH policies and procedures shall be submitted to LDH prior to Readiness Review. PSH Program staff will work with the Contractor to ensure consistent policies and procedures across MCOs.

2.7.14 Delegated Case Management

The Contractor may develop a program to delegate Case Management services to Providers, including reimbursement for services rendered. The purpose of such a program is to reimburse for Case Management services in settings where Enrollees are already accessing care and to avoid duplication with MCO Case Management services. If a program is established, it should:

2.7.14.1 Include PCPs, obstetrics and gynecology providers, and behavioral health providers.

2.7.14.2 Establish minimum provider qualifications for each tier of delegated Case Management services.

2.7.14.3 Establish criteria to distinguish when an Enrollee is eligible for delegated Case Management versus MCO Case Management. Wherever appropriate, the Contractor should utilize delegated Case Management for eligible Enrollees.

2.7.14.4 Establish monitoring and oversight procedures to ensure delegated Case Management providers are adhering to applicable Case Management requirements described in this Contract.

2.7.14.5 Establish a reimbursement rate for an initial assessment and POC development as well as a monthly reimbursement rate for each tier of Case Management services.

2.7.14.6 Be available to Enrollees that meet criteria and providers that meet minimum qualifications.

2.8 Continuity of Care

2.8.1 Continuity of Care and Care Transitions

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

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

2.8.1.3 The Contractor shall be responsible for the coordination and continuity of care of health care services for all Enrollees consistent with 42 CFR §438.208. In addition, the Contractor shall be responsible for coordinating with LDH, including the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, to ensure integrated support across behavioral health services and long-term supports and services.

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

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

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

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

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

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

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

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

2.8.1.4.8 Document authorized referrals in its utilization management system;

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

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

2.8.1.4.11 Continue the behavioral health therapeutic classes (including long-acting injectable antipsychotics) and other medication assisted treatment (including buprenorphine/naloxone and Naltrexone products) prescribed to the Enrollee in a mental health treatment facility for

at least sixty (60) Calendar Days after the facility discharges the Enrollee, unless the Contractor's psychiatrist, in consultation and agreement with the facility's prescribing physician, determines that the medications are:

2.8.1.4.11.1 Not medically necessary; or

2.8.1.4.11.2 Potentially harmful to the Enrollee.

2.8.2 Continuity of Care and Care Transitions for Behavioral Health

2.8.2.1 The PCP shall provide Basic Behavioral Health Services and refer the Enrollee(s) to the appropriate health care specialist as deemed necessary for SBHS.

2.8.2.2 The Contractor shall establish policies and procedures to facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs. Principles that guide care integration are as follows:

2.8.2.2.1 Mental illness and addiction are health care issues and shall be integrated into a comprehensive physical and behavioral health care system that includes primary care settings;

2.8.2.2.2 Many people suffer from both mental illness and addiction. As care is provided, both illnesses shall be understood, identified, and treated as primary conditions;

2.8.2.2.3 The system of care shall be accessible and comprehensive, and shall fully integrate an array of prevention and treatment services for all age groups. It shall be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement; and

2.8.2.2.4 It is important that relevant clinical information is accessible to both the primary care and behavioral health providers consistent with Federal and State laws, regulations, rules, policies, and other applicable standards of medical record confidentiality and the protection of patient privacy.

2.8.2.3 These policies and procedures shall include the following:

2.8.2.3.1 Mechanisms for collaborating with OJJ, DCFS, and DOE to coordinate the discharge and transition of children and youth in out-of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including the referral to necessary providers or a WAA if indicated;

2.8.2.3.2 Mechanisms for collaborating with nursing facilities and ICF/IIDs to coordinate aftercare planning prior to discharge and transition of Enrollees for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers;

2.8.2.3.3 Mechanisms to require collaboration from hospitals, residential facilities, and inpatient facilities to coordinate aftercare planning prior to discharge and transition of Enrollees for the

continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers and after-care appointments; and

2.8.2.3.4 Mechanisms for collaborating with the Department of Corrections and local criminal justice systems in Louisiana to facilitate access to and/or continuation of prescribed medication and other behavioral health services for Enrollees, including referral to community providers, prior to reentry into the community including, but not limited to, Enrollees in the Louisiana Medicaid Program pre-release program.

2.8.2.4 In any instance when the Enrollee presents to the Contractor, including calling the Contractor's toll-free number listed on the MCO Member ID Card, and an Enrollee is in need of emergency behavioral health services, the Contractor shall instruct the Enrollee to seek help from the nearest emergency medical provider. The Contractor shall initiate follow-up with the Enrollee within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.

2.8.2.5 The Contractor shall comply with all post-stabilization care service requirements found at 42 CFR §438.114.

2.8.2.6 The Contractor shall include documentation in the Enrollee's medical record that attempts are made to engage the Enrollee's cooperation and permission to coordinate the Enrollee's POC with the Enrollee's behavioral health and primary care provider.

2.8.2.7 The Contractor shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity of care.

2.8.2.8 These procedures shall address Enrollees with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services.

2.8.2.9 The Contractor shall provide or arrange for training of providers and other individuals involved in care management activities on identification and screening of behavioral health conditions and referral procedures.

2.8.3 Transitioning Between MCOs or FFS

2.8.3.1 The Contractor shall provide additional active assistance to Enrollees when transitioning between MCOs or FFS in accordance with a written policy, incorporating the requirements listed below, that ensures continued access to services during the transition.

2.8.3.2 The receiving MCO shall be responsible for activities that include, but are not limited to:

2.8.3.2.1 Ensuring the Enrollee has access to services consistent with the access they previously had, and is permitted to retain their current provider for a specified period of time if that provider is not in the Contractor's network;

2.8.3.2.2 Coordinating care with the relinquishing MCO so services are not interrupted;

2.8.3.2.3 Arranging for continuity of necessary care such as by making referrals to appropriate providers of services that are in network;

2.8.3.2.4 Adhering to the Service Authorization requirements as described under the *Service Authorization Requirements for New Enrollees* section*;*

2.8.3.2.5 If necessary, initiation of the request of transfer for the Enrollee's health record to the receiving MCO and the new PCP. The cost of reproducing and forwarding the health record to the receiving MCO shall be the responsibility of the relinquishing MCO; and

2.8.3.2.6 Any other necessary procedures as specified by LDH in writing to ensure continued access to services to prevent serious detriment to the Enrollee's health or reduce the risk of hospitalization or institutionalization.

2.8.3.3 The relinquishing MCO shall be responsible for activities that include, but are not limited to:

2.8.3.3.1 Ensuring Timely notification to the receiving MCO regarding pertinent information related to any health needs of transitioning Enrollees.

2.8.3.3.2 Fully and Timely complying with requests for historical utilization data from the receiving MCO in compliance with Federal and State laws, regulations, rules, policies, procedures, and manuals.

2.8.3.3.3 Consistent with Federal and State laws, regulations, rules, policies, procedures, and manuals, allowing the Enrollee's new provider(s) to obtain copies of the Enrollee's health record, as appropriate.

2.8.3.3.4 Any other necessary procedures as specified by LDH in writing to ensure continued access to services to prevent serious detriment to the Enrollee's health or reduce the risk of hospitalization or institutionalization.

2.8.3.4 If an Enrollee is to be transferred between MCOs but is hospitalized at the time, the transfer shall be effective on the date of Enrollment into the receiving MCO. However, the relinquishing MCO is responsible for the Enrollee's hospitalization until the Enrollee is discharged. The receiving MCO is responsible for all other care.

2.8.3.4.1 In the event that the relinquishing MCO's contract is terminated prior to the Enrollee's discharge, responsibility for the remainder of the hospitalization charges shall revert to the receiving MCO, effective at 12:01 a.m. on the Calendar Day after the relinquishing MCO's contract ends. LDH will identify and address any exceptions to this provision in the **MCO Manual**.

2.8.3.4.2 For newborns incorrectly enrolled, the relinquishing MCO is responsible for the newborn's hospitalization through the date of discharge.

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2.8.3.5 Special consideration shall be given to, but not limited to, the following:

2.8.3.5.1 Enrollees with significant conditions or treatments such as enteral feedings, oxygen, wound care, and ventilators, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition;

2.8.3.5.2 Enrollees who have received Prior Authorization for services such as scheduled surgeries, post-surgical follow up visits, therapies to be provided after transition or out-of-area specialty services;

2.8.3.5.3 Enrollees who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels or Enrollees who were born prematurely; and

2.8.3.5.4 Enrollees with significant medical conditions such as a high-risk pregnancy or pregnancy within the last thirty (30) Calendar Days, the need for organ or tissue transplantation, or chronic illness resulting in hospitalization.

2.9 Provider Network, Contracts, and Related Responsibilities

2.9.1 General Provider Network Requirements

2.9.1.1 The Contractor shall provide or ensure the provision of all MCO Covered Services specified in this Contract through the development and maintenance of an adequate provider network. Availability and accessibility of MCO Covered Services shall be in accordance with the Network Adequacy standards set forth in the applicable Federal regulations and this Contract, including, but not limited to, requirements set forth in Attachment F, *Provider Network Standards*.

2.9.1.2 The Contractor shall give assurances to LDH and provide supporting documentation that demonstrates that it has the capacity to serve the expected Enrollment in accordance with LDH's standards for access to care, including the standards at 42 CFR §438.68 and §438.206 and the access to care standards in Attachment F, *Provider Network Standards*, during Readiness Review, on an annual basis, and at any time there has been a Material Change in the Contractor's operations that would affect the adequacy of capacity and services. The Contractor's supporting documentation shall be in compliance with the **MCO Manual** and demonstrate that it:

2.9.1.2.1 Offers an appropriate range of preventive, primary care, and specialty services, including behavioral health specialty services, that is adequate for the anticipated number of Enrollees; and

2.9.1.2.2 Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees.

2.9.1.3 To demonstrate accessibility and availability of MCO Covered Services, the Contractor shall comply with all applicable reporting requirements. Achieving these minimum requirements shall not release the Contractor from the requirement to provide or arrange for the provision of any medically necessary MCO Covered Service required by its Enrollees, taking into account the urgency of the need for services.

2.9.1.4 In assessing network adequacy and compliance with this Contract, the Contractor shall identify, take into consideration, and separately report on provider specialists with limited Network Provider Agreements, such as single case agreements, in a format specified by LDH.

2.9.2 Availability and Furnishing of MCO Covered Services

2.9.2.1 The Contractor shall maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services covered under this Contract for all Enrollees, including those with limited English proficiency, physical, cognitive, or behavioral health disabilities. [42 CFR §438.206(b)(1)] For the purposes of determining network adequacy, the Contractor shall consider only those providers who meet the following criteria:

2.9.2.1.1 Physical health providers who have submitted at least one (1) Claim in an office setting within the prior twleve (12) calendar months;

2.9.2.1.2 Behavioral health providers who have submitted at least one (1) Claim within the prior twelve (12) calendar months; or

2.9.2.1.3 Any providers who were newly contracted within the prior twelve (12) calendar months, regardless of Claim submissions.

2.9.2.2 The Contractor shall ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Enrollees with physical, cognitive, or behavioral health disabilities [42 CFR §438.206(c)(3)].

2.9.2.3 If the Contractor is unable to provide the necessary services to an Enrollee within their network, the Contractor shall adequately and Timely cover these services out of network for the Enrollee for as long as the Contractor's provider network is unable to provide the services. The Contractor shall ensure coordination with respect to authorization and payment issues in these circumstances to ensure that the cost to the Enrollee is no greater than it would be if the services were furnished within the network [42 CFR §438.206(b)(4) and (5)].

2.9.2.4 The Contractor shall ensure parity in determining access to out-of-Network Providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes,

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strategies, evidentiary standards, or other factors in determining access to out-of-Network Providers for medical/surgical benefits in accordance with 42 CFR §438.910(d)(3).

2.9.3 Timely Access to Care

2.9.3.1 The Contractor shall meet and require its Network Providers to meet LDH standards for Timely access to care and services as specified in this Contract, taking into account the urgency of the need for services [42 CFR §438.206(c)(1)(i)].

2.9.3.2 The Contractor shall ensure that the Network Providers offer hours of operation to its Enrollees that are no less than the hours of operation offered to commercial Enrollees or comparable to FFS, if the provider serves only Enrollees [42 CFR §438.206(c)(1)(ii)]. The Contractor shall regularly disseminate appointment standards and procedures to its providers and Enrollees and include this information on the Contractor's provider website. The Contractor must include the applicable appointment accessibility standards from Attachment F, *Provider Network Standards*, in its Network Provider Agreements, either directly or through reference to the Contractor's Provider Manual.

2.9.3.3 The Contractor shall make services included in the Contract available twenty-four (24) hours a day, seven (7) days a week, when medically necessary [42 CFR §438.206(c)(1)(iii)].

2.9.3.4 The Contractor shall educate providers on the appointment accessibility standards of this Contract, evaluate provider compliance with these standards, and ensure that appointments with qualified providers are available to Enrollees on a Timely basis.

2.9.3.5 The Contractor shall establish mechanisms to ensure compliance with access requirements by Network Providers and shall monitor Network Providers regularly to determine compliance and shall take corrective action if there is a failure to comply by a Network Provider [42 CFR §438.206(c)(1)].

2.9.3.6 If the Contractor or LDH identifies or anticipates that the network will not be sufficient to meet the timely access to care standards of this Contract for an MCO Covered Service in any location or for any population of Enrollees, the Contractor shall enhance its provider network in order to meet such standards. The Contractor should notify LDH of its strategy for enhancing its network and its contingency plan for connecting impacted Enrollees to care which shall be made available upon LDH request in a format and frequency as determined by LDH.

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2.9.3.7 If LDH determines the Contractor has failed to ensure access to MCO covered services as defined in this contract and the MCO Manual for all

enrollees, including failure to provide timely responses, LDH may require corrective action or impose other remedies for non-compliance.

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2.9.4 Out-of-Network Protocols

2.9.4.1 The Contractor shall maintain and utilize protocols to address situations when the provider network is unable to provide an Enrollee with appropriate access to MCO Covered Services as defined in this Contract and the **MCO Manual**. The Contractor's protocols shall ensure, at a minimum, the following:

2.9.4.1.1 If the Contractor is unable to provide a particular MCO Covered Service through a Network Provider, it will be adequately covered in a Timely manner out-of-network;

2.9.4.1.2 That the particular service will be provided by a qualified and clinically appropriate provider;

2.9.4.1.3 That the provider shall be located within the shortest travel time of the Enrollee's residence, taking into account the availability of public transportation to the location;

2.9.4.1.4 That the provider is licensed by the State of Louisiana or, if located in another state, the provider is licensed by that state; and

2.9.4.1.5 That the provider is licensed and accredited by an LDH approved accrediting organization, if required by State or Federal requirements.

2.9.5 Requests for Exceptions to Access Requirements

2.9.5.1 The Contractor shall ensure PCP, OB/GYN, hospital, pharmacy, behavioral health, and other services identified in the Contract and the **MCO Manual** are available from Network Providers within the specified distance from the Enrollee's home. Exceptions, if any, to these distance standards shall be at the discretion of LDH and only considered based on the prevailing community standard.

2.9.5.2 The Contractor must submit any requests for exceptions for distance or appointment accessibility standards in writing to LDH for approval. Such requests must be in a format specified by LDH and include data on the local provider population available to the non-Medicaid population.

2.9.5.3 If LDH grants the Contractor an exception to a distance or appointment accessibility standard:

2.9.5.3.1 The exception is limited to the identified provider type and parish or parishes and is granted for a period of up to one (1) year, at which point the Contractor may submit a new request.

2.9.5.3.2 The Contractor shall monitor Enrollee access to the specific provider type on an ongoing basis and provide the findings to LDH as part of its Network Development and Management Plan. Specifically, the Contractor shall:

2.9.5.3.2.1 Describe how it shall reasonably deliver MCO Covered Services to Enrollees who may be affected by the exception and how it will work to increase access to the provider type in the designated parish or parishes; and

2.9.5.3.2.2 Monitor, track, and report to LDH on the delivery of MCO Covered Services to Enrollees potentially affected by the exception.

2.9.5.4 As permitted by Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, and applicable Waivers, telemedicine may be used to facilitate access to MCO Covered Services by licensed professionals. Any MCO Covered Service provided via telemedicine must be medically necessary, and the procedure individualized, specific, and consistent with symptoms or confirmed diagnosis of an illness or injury under treatment, and not in excess of the Enrollee's needs. If the Contractor intends to utilize telemedicine to meet network adequacy requirements, the Contractor's telemedicine utilization must be approved by LDH in writing for this purpose.

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2.9.6 Overall Network Management

The Contractor shall develop and implement a strategy to manage the provider network with a focus on Timely access to services for Enrollees, quality, consistent practice patterns, the principles of rehabilitation and recovery for behavioral health services, cultural and linguistic competence, and cost effectiveness.

2.9.6.1 The Contractor's network management strategy shall include at a minimum:

2.9.6.1.1 A system for utilizing Network Provider profiling and benchmarking data to identify and manage Outliers;

2.9.6.1.2 A system for the Contractor and Network Providers to identify and establish improvement goals and periodic measurements to track Network Providers' progress toward those improvement goals; and

2.9.6.1.3 Conducting on-site visits to Network Providers for quality management and quality improvement purposes.

2.9.6.2 The Contractor must conduct profiling activities for behavioral health providers and facilities and other provider types as directed by LDH. The Contractor must describe the methodology it uses to identify which and how many providers to profile and to identify measures to use for profiling such providers.

2.9.6.3 The Contractor shall use the results of its provider profiling activities to identify areas of improvement for providers, and/or groups of providers and establish provider-specific quality improvement goals for priority areas in which a provider(s) does not meet established Contractor standards or improvement goals;

2.9.6.4 The Contractor shall monitor and enforce access and other network standards required by this Contract and take appropriate action with providers whose performance is in need of improvement or out of compliance with this Contract, including when a provider fails to meet minimum provider qualifications or requirements, or appointment availability standards; and

2.9.6.5 The Contractor shall make collected information, monitoring reviews and findings, Corrective Action Plans and follow-up related to provider network management available to LDH upon request. At LDH's direction, the Contractor shall modify its network management strategy, tools, and processes to comply with the Contract and the **MCO Manual**.

2.9.7 Provider Participation

2.9.7.1 In accordance with 42 CFR §438.602(b) and upon LDH implementation of a provider management system, the Contractor and its Subcontractors shall not enter into a Network Provider Agreement with a provider to provide services to Beneficiaries or reimburse a Claim containing a provider's NPI when the provider is not otherwise appropriately screened by and enrolled with the State according to the standards under 42 CFR Part 455, Subparts B and E. Such Enrollment includes providers that order, refer, or furnish services under the State Plan and Waivers. Such Enrollment does not obligate providers to participate in FFS.

2.9.7.2 The Contractor may execute Network Provider Agreements pending the outcome of the State screening, Enrollment, and re-validation process for up to one hundred twenty (120) Calendar Days, but upon notification from the State that a provider's Enrollment has been denied or terminated, or the expiration of the one hundred twenty (120) Calendar Day period without Enrollment of the provider, the Contractor shall terminate such Network Provider immediately and notify affected Enrollees in writing that the provider is no longer participating in the network.

2.9.7.3 Prior to contracting with a Network Provider and/or paying a provider's Claim, the Contractor shall ensure that the provider has a valid National Provider Identifier (NPI) Number, where applicable, has a valid license or certification to perform services in the State, has not been excluded or barred from participation in Medicare, Medicaid, CHIP, and/or any other government healthcare program and has obtained a Medicaid provider number from LDH.

2.9.7.4 The Contractor shall comply Timely with all non-compliance actions imposed by the State on Network Providers, including Enrollment revocation, termination, and exclusions.

2.9.7.5 For the following qualified providers, the Contractor shall offer a Network Provider Agreement and also have LDH's written approval prior to terminating the agreements:

2.9.7.5.1 Louisiana Office of Public Health (OPH);

2.9.7.5.2 All OPH-certified School Based Health Clinics (SBHCs);

2.9.7.5.3 All small rural hospitals meeting the definition in the Rural Hospital Preservation Act;

2.9.7.5.4 Federally Qualified Health Centers (FQHCs);

2.9.7.5.5 Rural Health Clinics (RHCs) (free-standing and hospital based);

2.9.7.5.6 Clinics and outpatient providers funded under the HRSA administered Ryan White HIV/AIDS Program;

2.9.7.5.7 OPH Family Planning clinics and providers, including those funded by Title X of the Public Health Service Act;

2.9.7.5.8 Opioid Treatment Programs;

2.9.7.5.9 All providers approved in writing by the LDH PSH Program to provide tenancy and pre-tenancy supports for the Louisiana Permanent Supportive Housing program;

2.9.7.5.10 Local Governing Entities; and

2.9.7.5.11 Providers that are actively serving the Contractor's Enrollees that are eligible under the Act 421 Children's Medicaid Option, subject to 42 CFR §431.52 and excluding ICF/IIDs; and

2.9.7.5.12 All Louisiana Crisis Response System (LaCRS) providers.

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

2.9.7.7 Notwithstanding the requirements of this Section, the Contractor may limit provider participation to the extent necessary to meet the needs of the Contractor's Enrollees. These provisions also do not interfere with measures established by the Contractor to control costs and quality consistent with its responsibilities under this Contract nor does it preclude the Contractor from using different reimbursement amounts, which may be greater than the published FFS Rate, for different specialists or for different practitioners in the same specialty [42 CFR §438.12(b)].

2.9.7.8 If the Contractor declines requests of individuals or groups of providers to be included in its provider network, the Contractor shall give the affected

providers written notice of the reason for its decision within fourteen (14) Calendar Days of its decision [42 CFR §438.12(a)(1)].

2.9.8 Exclusion from Participation

2.9.8.1 The Contractor shall not pay Claims to or execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either 42 U.S.C. §1320a-7 or §1320a-7a [42 CFR §438.214(d)] or State funded health care programs. The Contractor may access a list of providers excluded from Federal health care programs using the sources provided in the **MCO Manual**.

2.9.8.2 The Contractor shall not contract or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to 42 U.S.C. §1320a-7 or 42 U.S.C. §1320c-5 or who are otherwise barred from participation in the Medicaid and/or Medicare program. This includes providers currently undergoing any of the following conditions identified through LDH proceedings:

2.9.8.2.1 Revocation of the provider's license;

2.9.8.2.2 Exclusion from the Medicaid program;

2.9.8.2.3 Termination from the Medicaid program;

2.9.8.2.4 Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and Utilization Review Subsystems (SURS) Rule (LAC 50:I.Chapter 41);

2.9.8.2.5 Provider fails to Timely renew its license; or

2.9.8.2.6 The Louisiana Attorney General's Office has seized the assets of the service provider.

2.9.8.3 The Contractor shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

2.9.8.4 The Contractor shall not remit payment for services provided under this Contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories.

2.9.9 Other Enrollment and Disenrollment Requirements

2.9.9.1 The Contractor shall not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State laws, rules, and regulations, solely on the basis of that licensure or certification.

2.9.9.2 The Contractor shall establish and follow a documented process for credentialing and re-credentialing of Network Providers [42 CFR §438.12(a)(2) and §438.214]. In addition, the Contractor shall not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR §438.214(c)].

2.9.9.3 The Contractor shall require that all providers comply with Americans with Disabilities Act (ADA) requirements and provide access for Enrollees with disabilities.

2.9.9.4 Prior to reimbursing entities rendering and receiving reimbursement for Mental Health Rehabilitation (MHR) services, inclusive of Evidence-Based Practice (EBP) MHR services, the contractor shall:

2.9.9.4.1 Ensure all MHRs:

2.9.9.4.1.1 Require all staff to obtain and submit NPI numbers to the Contractor,

2.9.9.4.1.2 Ensure that all claims for MHR services include rendering provider NPIs and other Contractor required identifiers regardless of whether the rendering staff is licensed or unlicensed; and

2.9.9.4.1.3 Submit documentation demonstrating compliance with all staff qualifications and requirements established by applicable Federal and State laws, rules, regulations, and the Medicaid Behavioral Health Service Provider Manual, prior to services being rendered.

2.9.9.4.2 Collect and review documentation, prior to approving reimbursement for MHR services, of all required qualifications at:

2.9.9.4.2.1 Credentialing;

2.9.9.4.2.2 Upon hiring new staff; and

2.9.9.4.2.3 During re-credentialing to maintain ongoing compliance;

2.9.9.4.3 Implement claims processing system edits to deny claims for services when rendering provider NPIs appear on claims submissions but have not been verified and approved by the Contractor; and

2.9.9.4.4 Submit policies and procedures associated with this requirement to LDH or its designee for approval during Readiness Review.

Deleted: The Contractor shall require unlicensed staff of entities rendering and receiving reimbursement for Mental Health Rehabilitation (MHR) services to obtain and submit NPI numbers to the Contractor, as well as documentation verifying the unlicensed staff meets all qualifications and requirements for providing MHR services established by applicable Federal and State laws, rules, regulations, and the Medicaid Behavioral Health Service Provider Manual, inclusive of Evidence-Based Practice (EBP) MHR services, prior to reimbursing agencies for services provided by these staff. Claims submitted for MHR services shall include rendering provider NPIs and other Contractor required identifiers regardless of whether the rendering staff is licensed or unlicensed. The Contractor shall configure systems to deny Claims for services when rendering providers and NPIs are denoted on Claims for service that have not been credentialed and approved by the Contractor. The Contractor shall submit their policies and procedures associated with this requirement to LDH or its designee for approval during Readiness Review.

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2.9.9.5 If the Contractor terminates a Network Provider Agreement for cause, the Contractor shall provide written notice to the provider within one (1) Business Day of the decision being made. The notice shall be sent at least

fifteen (15) Calendar Days prior to the effective date of termination via electronic means and within one (1) Business Day of the decision being made via certified mail. The Contractor shall notify LDH through email prior to provider notification. The termination shall be immediate if the termination is pursuant to La. R.S. 46:460.73(B), due to the loss of required license, or due to health and safety concerns.

2.9.9.6 The Contractor shall notify LDH when the Contractor or its Subcontractor terminates a Network Provider Agreement for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

2.9.9.7 If the Contractor terminates a Network Provider Agreement without cause, the Contractor shall be responsible for the following:

2.9.9.7.1 Identifying and providing to LDH an accounting of all Enrollees who have received services from the impacted provider within the past eighteen (18) months by, at minimum, Claims analysis and PCP selection concurrently with the notification to LDH;

2.9.9.7.2 Submission of a letter informing Enrollees of the termination and their ability to change their MCO, if appropriate, to LDH within five (5) Business Days of notification to LDH;

2.9.9.7.3 Receiving and inputting in the Beneficiary Enrollment web-based system Enrollee Disenrollment requests resulting from the termination within five (5) Business Days of the receipt of the request; and

2.9.9.7.4 The administrative cost borne by LDH for Disenrollments resulting from the termination, as invoiced by LDH.

2.9.9.8 When a Network Provider Agreement is terminated, with or without cause, the Contractor shall also provide to LDH its plan to notify the Contractor's Enrollees of such change, its strategy to ensure Timely access for Enrollees through different in-network and/or out-of-Network Providers, and its plan for ensuring that there will be no stoppage or interruption of services to Enrollees.

2.9.9.9 The Contractor shall notify its Enrollees of provider terminations in accordance with the *Enrollee Services* section.

2.9.9.10 The Contractor shall notify the State's provider management contractor of a Network Provider's termination by close of business on the next Business Day following the termination.

2.9.10 Mainstreaming

2.9.10.1 LDH considers mainstreaming of Enrollees into the broader health delivery system to be important. The Contractor shall ensure that all Network Providers accept Enrollees for treatment and that Network

Deleted: <#>The Contractor may not terminate Network Provider Agreements without cause during the period of forty-five (45) Calendar Days prior to the start of the Enrollment period through the last Calendar Day of the Enrollment period.

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Providers do not intentionally segregate Enrollees in any way from other persons receiving services.

2.9.10.2 To ensure mainstreaming of Enrollees, the Contractor shall take affirmative action to confirm that Enrollees are provided MCO Covered Services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical, behavioral, or cognitive disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

2.9.10.2.1 Denying or not providing to an Enrollee any medically necessary MCO Covered Service or availability of a facility; and

2.9.10.2.2 Discriminatory practices with regard to Enrollees such as separate waiting rooms, separate appointment days, separate physical locations, or preference to private pay or FFS patients.

2.9.10.3 When the Contractor becomes aware of a Network Provider's failure to comply with mainstreaming, the Contractor shall develop a written plan for coming into compliance with the Contract requirement for mainstreaming with the Network Provider within thirty (30) Calendar Days and provide the plan to LDH in writing.

2.9.10.4 The Contractor shall ensure that providers do not exclude treatment or placement of Enrollees for authorized behavioral health services solely on the basis of State agency (DCFS, OCDD, or OJJ, etc.) involvement or referral.

2.9.11 Primary Care

The PCP shall serve as the Enrollee's initial and most important point of interaction with the Contractor's provider network. A PCP shall be an individual physician, nurse practitioner, or physician assistant who accepts primary responsibility for the management of an Enrollee's health care. The primary care provider is the Enrollee's point of access for preventive care or an illness and may treat the Enrollee directly, refer the Enrollee to a specialist (secondary/tertiary care), or admit the Enrollee to a hospital.

2.9.11.1 PCP Selection

The Contractor shall:

2.9.11.1.1 Allow each Enrollee to choose his or her PCP and other health care professionals to the extent possible and appropriate;

2.9.11.1.2 Make best efforts to assist and encourage each Enrollee to select a PCP. Such best efforts shall include, but not be limited to, providing interpreter services when necessary to assist the Enrollee in choosing a PCP, making efforts to contact those Enrollees who have not contacted

the Contractor and, in the case of children in the care or custody of DCFS, making efforts to contact the child's State caseworker through the LDH appointed DCFS liaison; and

2.9.11.1.3 Assist Enrollees in selecting a PCP, within fifteen (15) Calendar Days after their effective date of Enrollment, by eliciting information on prior PCP affiliations that the Enrollee may have had and providing the Enrollee with relevant information on adult or pediatric PCPs in close proximity to the Enrollee, including providing information regarding the experience of the PCP in treating special populations if known to be applicable.

2.9.11.2 PCP Automatic Assignment

2.9.11.2.1 The Contractor is responsible for developing a PCP Automatic Assignment methodology in collaboration with LDH to assign to a PCP an Enrollee for whom the Contractor is the primary payor when the Enrollee:

2.9.11.2.1.1 Does not make a PCP selection;

2.9.11.2.1.2 Selects a PCP within the network that has reached its maximum physician/patient ratio;

2.9.11.2.1.3 Selects a PCP within the network that has restrictions/limitations (e.g. pediatric only practice); or

2.9.11.2.1.4 Does not make a selection of a PCP for a newborn within fourteen (14) Calendar Days of birth.

2.9.11.2.2 In the event that the Enrollee has not selected a PCP and the Contractor is unable to elicit a PCP selection from an Enrollee, the Contractor shall promptly assign a PCP to each such Enrollee as described below. The assignment shall be to the most appropriate PCP in accordance with this Contract, the **MCO Manual**, and the Contractor's approved PCP Automatic Assignment methodology, as approved by LDH in writing. The PCP assignment shall be effective no later than fifteen (15) Calendar Days after the effective date of Enrollment with the Contractor. For a newborn, the PCP assignment shall be effective no later than the first month of Enrollment subsequent to the birth of the child.

2.9.11.2.3 The Contractor's PCP Automatic Assignment methodology shall be subject to LDH approval as part of Readiness Review and fifteen (15) Calendar Days prior to any subsequent changes in the Contractor's assignment methodology unless otherwise agreed to in writing by LDH. The Contractor shall make its PCP assignment methodology readily available to LDH and via the Contractor's website, provider handbook, and Member Handbook and upon request.

2.9.11.3 PCP Designation for Enrollees

2.9.11.3.1 If a new Enrollee has informed the Enrollment Broker of a PCP selection, the name of the PCP requested by the Enrollee will be included in the Enrollee file from the Enrollment Broker to the Contractor. The Contractor shall confirm the PCP selection information received in the Enrollee File in a written notice to the Enrollee within ten (10) Business Days of receiving the file.

2.9.11.3.2 For any Enrollee who has not yet selected or been assigned a PCP, the Contractor shall, within three (3) Business Days after receiving notification that such Enrollee seeks to or has obtained care, in or out of the provider network, contact the Enrollee and assist the Enrollee in choosing a PCP. If the Contractor is unable to reach the Enrollee, then the Contractor shall assign a PCP to such Enrollee and affirmatively notify the Enrollee and the PCP of the assignment as required in this Contract.

2.9.11.3.3 At least monthly, the Contractor shall share complete lists of designated Enrollees with PCPs. The Contractor shall have a process, not to exceed fifteen (15) Business Days, by which a PCP may dispute the Contractor's assignment policies or the assignment of an Enrollee. The Contractor shall submit its dispute process to LDH or its designee during Readiness Review.

2.9.11.3.4 The Contractor shall be responsible for providing to the Enrollment Broker, information on the number of Enrollees in each PCP panel and remaining capacity of each individual PCP on a quarterly basis. The Contractor shall submit a listing for each PCP, the Enrollees that are designated, via selection or PCP Automatic Assignment, to that PCP's panel to LDH weekly as described in the **MCO Manual** and the **MCO System Companion Guide.**

2.9.11.3.5 The Contractor shall:

2.9.11.3.5.1 Monitor, on an ongoing basis, the completeness and accuracy of the PCP designations for all Enrollees;

2.9.11.3.5.2 Annually, and at other frequencies specified by LDH, audit PCP designations for Enrollees to identify Enrollees with no PCP designation or an incorrect PCP designation;

2.9.11.3.5.3 Take steps to rectify identified errors and gaps in PCP designations, such as through reconciliation of information provided by the Enrollee, the PCP, and/or the Contractor's records, and facilitation of Enrollee selection of a PCP, or assignment of Enrollees to PCPs;

2.9.11.3.5.4 Conduct root cause analyses, and implement activities to maximize proactively the completeness and accuracy of PCP designations;

2.9.11.3.5.5 Annually, and at other frequencies specified by LDH, assess its PCP assignment methodology by conducting a Claims/Encounter-based analysis utilizing available historical information about Enrollee use of health care services to identify which providers and primary care services the Enrollees used over a period of time, and consider providers that have billed for evaluation and management codes, including those for wellness care. Based on this analysis the Contractor shall offer to change PCPs for Enrollees and shall consider changes to its PCP assignment methodology to improve care and case management; and

2.9.11.3.5.6 Annually submit to LDH an Enrollee-PCP assignment report in a format and frequency to be specified by LDH, such report shall include results of the Contractor's Enrollee-PCP assignment monitoring efforts and the actions taken by the Contractor in the prior twelve (12) months.

2.9.11.4 PCP Transfers

The Contractor shall:

2.9.11.4.1 Allow an Enrollee to change PCPs, at least once, during the first ninety (90) Calendar Days from the Enrollee's selection of or assignment to a PCP without cause and shall allow such a PCP transfer request to go in effect immediately;

2.9.11.4.2 At the Enrollee's request, allow the Enrollee to change his or her PCP with cause at any time and allow for Enrollment with the new PCP to be effective immediately;

2.9.11.4.3 Have written policies and procedures for allowing Enrollees to select a new PCP and provide information to Enrollees on options for selecting a new PCP; and

2.9.11.4.4 Define what is considered as cause in written policies to include, but not be limited to, when an Enrollee has moved, a PCP is non-compliant with provider standards or is terminated from the Contractor, or when a PCP change is ordered as part of the resolution to a Grievance proceeding.

2.9.11.5 PCP Responsibilities

2.9.11.5.1 The Contractor shall ensure that network PCPs fulfill their responsibilities including, but not limited to, the following:

2.9.11.5.1.1 Managing and coordinating the medical and behavioral health care needs of Enrollees to ensure that all medically necessary services are made available in a Timely manner;

2.9.11.5.1.2 Referring patients to specialists or subspecialists and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available;

2.9.11.5.1.3 Communicating with all other levels of medical care to coordinate, and follow up the care of individual patients;

2.9.11.5.1.4 Providing the coordination necessary for the referral of patients to specialists or subspecialists;

2.9.11.5.1.5 Maintaining a medical record of all services rendered by the PCP and a record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow up and/or coordination of care;

2.9.11.5.1.6 Development of plans of care to address risks and medical needs and other responsibilities as defined in this section;

2.9.11.5.1.7 Ensuring that in the process of coordinating care, each Enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164 and all State statutes. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information;

2.9.11.5.1.8 Providing after-hours availability to patients who need medical advice. At a minimum, the PCP office shall have a return call system staffed and monitored in order to ensure that the Enrollee is connected to a designated medical practitioner within thirty (30) minutes of the call;

2.9.11.5.1.9 Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at a Contractor participating hospital;

2.9.11.5.1.10 Working with Contractor case managers to develop plans of care for Enrollees receiving case management services;

2.9.11.5.1.11 Participating in the Contractor's case management team, as applicable and medically necessary; and

2.9.11.5.1.12 Conducting screens for common behavioral issues, including, but not limited to, depression, anxiety, trauma/ ACEs, and substance use, early detection, identification of developmental disorders/delays, social-emotional health, and SDOH to determine whether the Enrollee needs behavioral health services.

2.9.11.5.2 The Contractor shall seek to contract with adult and pediatric PCPs that offer extended primary care hours and shall review adult and pediatric primary care, urgent care and ED utilization patterns across different regions and parishes to assess access to care.

2.9.11.5.3 At least annually, according to a format specified by LDH, the Contractor shall:

2.9.11.5.3.1 Report on the number and percentage of adult PCPs with extended primary care hours (nights and weekends) that are not closed to new patients;

2.9.11.5.3.2 Report on the number and percentage of pediatric PCPs with extended primary care hours (nights and weekends) that are not closed to new patients; and

2.9.11.5.3.3 Review primary care, urgent care and ED utilization patterns to identify regions and parishes that appear to have significant primary care access constraints for adults or children.

2.9.12 Specialty Providers

2.9.12.1 The Contractor shall ensure access to specialty providers, as appropriate, for all Enrollees. The Contractor shall ensure access standards and guidelines to specialty providers are met as specified in this Contract.

2.9.12.2 The Contractor's provider network shall include participating specialists with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (e.g. a pediatric cardiologist).

2.9.12.3 The Contractor shall ensure access to appropriate service settings for Enrollees needing medically high-risk perinatal care, including both prenatal and neonatal care.

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

2.9.12.4.1 The Contractor has signed a contract with providers of the specialty types listed in the **MCO Manual** who accept new Enrollees and are available on at least a referral basis; and

2.9.12.4.2 The Contractor is in compliance with access and availability requirements for these specialty types.

2.9.12.5 The Contractor shall ensure, at a minimum, the availability of specialists in compliance with the ratio, distance, and appointment time requirements set in Attachment F, *Provider Network Standards*.

2.9.12.6 The Contractor will be required to provide a higher ratio of specialists per Enrollee population and/or additional specialist types/Enrollee ratios may be established, if it is determined by LDH that the Contractor does not meet the access standards specified in Attachment F, *Provider Network Standards*.

2.9.12.7 In accordance with 42 CFR §438.208(c)(4), for Enrollees with SHCN determined to need a course of treatment or regular monitoring, the Contractor shall have a mechanism in place to allow Enrollees to directly access a specialist as appropriate for the Enrollee's condition and identified needs.

2.9.13 Hospitals

2.9.13.1 The Contractor shall ensure that hospital service providers utilized by Enrollees meet the conditions required for participation under the Louisiana Medicaid Program. This applies to non-Network Providers when circumstances allow.

2.9.13.2 The Contractor shall include, at a minimum, access to the following:

2.9.13.2.1 One (1) hospital that provides Emergency Room Care, inpatient, and outpatient care in each parish in the state, provided the parish has such a hospital.

2.9.13.2.2 The Contractor must establish access to one of the following per region, at a minimum and to the extent available, within their network of hospitals:

- Level III Obstetrical services;
- Level III Neonatal Intensive Care (NICU) services;
- Pediatric services;

- Trauma services;
- Burn services; and
- A Children's Hospital that meets the CMS definition in 42 CFR §495.302 and §412.23(d).

2.9.14 Tertiary Care

Tertiary care is defined as health services provided by highly specialized providers, such as medical sub-specialists; these services frequently require complex technological and support facilities. The Contractor shall provide tertiary care services including trauma centers, burn centers, level III (high-risk) nurseries, rehabilitation facilities, and medical sub-specialists twenty-four (24) hours per day. If the Contractor does not have a full range of tertiary care services, the Contractor shall have a process for providing such services including transfer protocols and arrangements with out-of-Network Providers.

2.9.15 Access to Medications for Opioid Use Disorder (MOUD)

2.9.15.1 The Contractor shall ensure that substance use residential providers offer onsite access to Medicaiton for Opioid Use Disorder (MOUD) in accordance with R.S. 40:2159.1. MOUD in this case is defined as at least one form of opioid antagonist (naltrexone oral/injectable) and at least one form of partial opioid agonist (buprenorphine oral/injectable) .

2.9.15.2 The Contractor shall report on Enrollee access to MAT in a format and frequency specified in the **MCO Manual**.

2.9.15.3 The Contractor shall be responsible for conducting Enrollee outreach and provider education and training regarding utilization of ~~MAT~~**MOUD** to treat Opioid Use Disorder.

2.9.15.4 LDH may pursue SPAs or Waivers to expand the substance use service array to include additional American Society of Addiction Medicine (ASAM) criteria and/or levels of care, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines.

2.9.16 Direct Access to Specialists for HIV Positive Enrollees

The Contractor shall provide direct access to an infectious disease health specialist(s) in-network for Enrollees known to be HIV positive. This access shall be in addition to the Enrollee's PCP if that provider is not an infectious disease specialist.

2.9.17 Direct Access to Women's Health Care

The Contractor shall provide direct access to a health specialist(s) in-network for MCO Covered Services necessary to provide women's routine and preventive health care and

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gynecology services. This access shall be in addition to the Enrollee's PCP if that provider is not a women's health specialist.

2.9.17.1 The Contractor shall demonstrate that its network includes sufficient family planning providers to ensure Timely access to MCO Covered Services.

2.9.17.2 The Contractor shall notify and give each Enrollee, including adolescents, the opportunity to use their own PCP or utilize any family planning service provider for family planning services without requiring a referral or authorization. Family planning services shall be available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments, and traditional contraceptive devices. The Contractor's family planning services shall also include preconception and interconception care services to optimize the Enrollee's health entering pregnancy. The Contractor shall agree to make available all family planning services to Enrollees as specified in this Contract.

2.9.17.3 Enrollees shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the Contractor's provider network without any restrictions as specified in 42 CFR §431.51(b)(2). The out-of-network Medicaid enrolled family planning services provider shall bill the Contractor and be reimbursed no less than the FFS Rate in effect on the date of service. Enrollees shall be encouraged by the Contractor to receive family planning services through the Contractor's network of providers to ensure continuity and coordination of the Enrollee's total care. No additional reimbursements shall be made to the Contractor for Enrollees who elect to receive family planning services outside the Contractor's provider network.

2.9.17.4 The Contractor may require family planning providers to submit Claims or reports in specified formats before reimbursing services.

2.9.17.5 The Contractor shall maintain the confidentiality of family planning information and records for each Enrollee including those under the age of majority.

2.9.18 Prenatal Care Services

2.9.18.1 The Contractor shall assist all pregnant Enrollees in choosing a pediatrician, or other appropriate PCP, for the care of their newborn babies before the beginning of the last trimester of gestation. The Contractor shall report to LDH on a quarterly basis the number and percentage of newborns for which a PCP has been selected prior to birth.

2.9.18.2 In the event that the pregnant Enrollee does not select a pediatrician, or other appropriate PCP, the Contractor shall provide the Enrollee with a

minimum of fourteen (14) Calendar Days after birth to select a PCP prior to assigning one.

2.9.18.3 The Contractor shall ensure that Enrollees who are pregnant begin receiving care within the first trimester or within seven (7) Calendar Days after enrolling with the Contractor. The Contractor shall provide available, accessible, and adequate numbers of prenatal care providers to provide prenatal services, including SBHS that are incidental to a pregnancy (in accordance with 42 CFR Part 440, Subpart B) to all Enrollees.

2.9.19 Other Service Providers

The Contractor shall ensure the availability of medical service providers including, but not limited to, ambulance services, durable medical equipment, orthotics, prosthetics and certain supplies, radiology, and laboratories.

2.9.20 NEMT and NEAT

2.9.20.1 The Contractor shall have sufficient NEMT and NEAT providers, including wheelchair lift equipped vans, to transport Enrollees to/from medically necessary services when notified forty-eight (48) hours in advance. NEMT and NEAT providers shall pick up Enrollees no later than three (3) hours after notification by an inpatient facility of a scheduled discharge or two (2) hours after the scheduled discharge time, whichever is later.

2.9.20.2 If an Enrollee requests a Network Provider who is located beyond the access standards provided in Attachment F, *Provider Network Standards*, and the Contractor has an appropriate provider within the access standards who accepts new patients, it shall not be considered a violation of the access requirements for the Contractor to grant the Enrollee's request. However, in such cases, the Enrollee shall be responsible for travel arrangements and costs to access care from this selected provider.

2.9.21 FQHC/RHC Clinic Services

2.9.21.1 The Contractor shall offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) in the State.

2.9.21.2 See the *Provider Reimbursement* section for FQHC/RHC reimbursement requirements.

2.9.22 School-Based Health Clinics (SBHCs)

2.9.22.1 SBHC (certified by LDH OPH) services are those Medicaid Covered Services provided within school settings to Beneficiaries under the age of twenty-one (21).

2.9.22.2 The Contractor shall offer a contract to each SBHC. The Contractor may stipulate that the SBHC follow all of the Contractor's required policies and procedures.

2.9.23 Laboratory

All laboratory testing sites providing services under this Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or Waiver of a certificate of registration along with a CLIA identification number.

2.9.24 Local Parish Health Clinics

2.9.24.1 The Contractor shall offer a contract to OPH for the provision of personal health services offered within the parish health units (e.g. immunizations, STI, family planning).

2.9.24.2 The Contractor shall coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for addressing public health issues shall be negotiated with LDH and reflect Louisiana public health priorities. The coordination of activities related to public health shall take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF, and the Contractor.

2.9.25 Specialized Behavioral Health Providers

2.9.25.1 The Contractor shall ensure behavioral health services are offered to address the needs of youth with serious emotional disorders, adults with Serious Mental Illness (SMI), Enrollees with substance use disorders, Enrollees with co-occurring mental health and substance use disorders and other developmental disorders. This shall include coordination with the Local Governing Entities (LGEs) for the provision of Medicaid Covered Services.

2.9.25.2 The Contractor shall ensure its provider network offers a range of Basic Behavioral Health Services and SBHS as reflected in the **MCO Manual** and meets the network adequacy standards defined in this Contract. The provider network shall be adequate for the anticipated number of Enrollees for the service area.

2.9.25.3 The Contractor shall develop its network to meet the needs of Enrollees, including but not limited to, providing assessment to identify and treat the behavioral health needs of Enrollees with past history or current display of aggression, runaway behavior, sexual offenses, or intellectual disability.

2.9.25.4 The Contractor shall develop, in coordination with LDH and other MCOs, a system to provide psychiatric prescribing support to primary care

providers. Such support may be provided through consultation with psychiatrists regarding psychiatric prescribing practices.

2.9.25.5 The Contractor shall endorse real time consultation of primary care providers with behavioral health professionals or psychiatrists for behavioral health issues or consultations on medications.

2.9.25.6 The Contractor shall design its provider network to maximize the availability of community-based behavioral health care that reduces utilization of Emergency Services when lower cost community-based services are available and eliminates preventable hospital, nursing home, and other institutional admissions. The Contractor shall coordinate with other State agencies, as appropriate, to match services to meet behavioral health needs in the community with services and supports to meet the Enrollee's other needs in the community, such as I/DD.

2.9.25.7 The Contractor shall design its provider network to increase the emerging use of peers as providers. This includes peers providing services for youth, adults and parents/families served in community and residential settings, and certified peer support specialists with OBH approved credentials to serve as qualified providers.

2.9.25.8 The Contractor shall ensure the provider network has a sufficient number of prescribers and other qualified behavioral health service providers to deliver services during evenings and weekends.

2.9.25.9 The Contractor shall have a fully operational network of behavioral health crisis response Providers offering a complete array of crisis response services operating in compliance with state-established licensing and service standards outlined iwthin the Medicaid Behavioral Health Services Provider Manual. Crisis response services shall include twenty-four (24)-hour access to crisis intervention services, including crisis stabilization for children and adults, mobile crisis response teams, community brief crisis support and behavioral health crisis care. Louisiana crisis services will be delivered in the least restrictive setting using approaches that minimize the use of coercive interventions. These crisis services will allow Enrollees to receive services in the community rather than in EDs when there are no medical or other contraindications to doing so. The Contractor shall maintain an active role in managing the process to ensure resolution of behavioral health crises in the community and referral to and assistance with placement in behavioral health services required by the individual in need. This includes collaboration with the Louisiana Crisis Hub (LCH) and crisis providers in conformance with service standards outlined within the **Louisiana Crisis Response System Companion Guide**.

2.9.25.10 The Contractor shall also coordinate with community resources, including but not limited to, law enforcement, emergency departments, statewide and regional crisis coalitions, dispatch call centers (including 911 and the

LCH), and emergency management service organizations personnel, to expand the crisis response. The community-based crisis response system may include other innovative approaches to crisis services beyond that which is established as reimbursable through the Louisiana Medicaid Program. The Contractor shall familiarize itself with the local crisis collaborative and work with it to facilitate crisis resolution.

2.9.25.11 The Contractor will work with LDH on strategies to reduce the need for services delivered in EDs, or the involvement of law enforcement in crisis response when it can be safely avoided. This includes the use of law enforcement for transportation.

2.9.25.12 The Contractor shall educate Enrollees on the availability of crisis services, and the statewide phone number for accessing the services.

2.9.25.13 The Contractor shall work with LDH and other entities as identified by LDH to develop a robust continuum of behavioral health crisis responses that includes services ranging across the crisis continuum to include the following:

2.9.25.13.1 Crisis prevention and crisis planning by outpatient treatment providers;

2.9.25.13.2 Early crisis intervention by outpatient treatment Providers;

2.9.25.13.3 Acute crisis intervention;

2.9.25.13.4 Crisis treatment (including alternatives to inpatient treatment); and

2.9.25.13.5 Post-crisis supports and strategies to prevent need for extended inpatient or admission to other congregate living.

2.9.25.14 The Contractor will also be responsible for facilitating or participating in state/local crisis system of care collaboratives/workgroups with a focus on care coordination, review of performance data, assessment and remediation of gaps and needs, and other crisis system improvement strategies

2.9.25.15 The Contractor must ensure that Contractor's staff who have direct Enrollee contact know the continuum of community resources for behavioral health crisis services, including crisis lines and the appropriate crisis services available within each region.

2.9.25.16 The Contractor must train Contractor's staff who interface with the public or have direct Enrollee contact how to connect (through direct linkages) Enrollees in need of behavioral health crisis services to the appropriate crisis services.

2.9.25.17 The Contractor must track and document behavioral health crisis contacts from Enrollees in conjunction with the LCH and ensure that this

information is shared as soon as possible and no later than the next Business Day with the Contractor case manager, community case management Provider, Assertive Community Treatment (ACT) Team if appropriate or other behavioral health Provider for appropriate follow-up.

2.9.25.18 The Contractor will perform Timely authorization, if required, for crisis services in order to minimize wait time before those services can commence and to assure the efficient operation of the crisis system of care.

2.9.25.19 The Contractor must contract with all Providers identified by LDH as eligible to provide crisis services. When there are instances of quality concerns that place the provider's contract in jeopardy, the Contractor must immediately notify LDH if it is not willing to contract with a particular crisis Provider and must collaborate with LDH on next steps, which must include a plan to assure Timely delivery of services in the geographic area covered by the Provider of concern.

2.9.25.20 The Contractor must monitor crisis Providers for compliance with LDH's standards and guidance using a standardized protocol as specified by LDH. As directed by LDH, the Contractor must coordinate monitoring activities with other Contractors.

2.9.25.21 If shortages in provider network sufficiency are identified by LDH, the Contractor shall conduct outreach efforts approved by LDH in writing, and take necessary actions to ensure Enrollee access to medically necessary behavioral health services. The Contractor shall execute an ad hoc or single case agreement when a clinical need or a specialized behavioral health service is identified for an Enrollee and a Network Provider is not available to meet that particular need. In such cases, all transportation necessary to receive medically necessary services shall be provided and reimbursed through the Contractor, including meals and lodging as appropriate.

2.9.25.22 The Contractor shall ensure that all placements are at the most appropriate, least restrictive, and medically necessary level to treat the specialty needs of the Enrollee. The Contractor shall defer to the responsible State agencies regarding the appropriateness of residential placement options for Long Term Supports and Services outside of the scope of this Contract. Institutional placements should not be viewed as substitutes for needed behavioral health treatment.

2.9.25.23 The Contractor shall require behavioral health providers to screen for basic medical issues.

2.9.25.24 The Contractor shall monitor and support development of local provider capacity for the purpose of identifying and filling gaps in service availability.

2.9.25.25 The Contractor shall report the number of out-of-state placements as specified by LDH. LDH may require the Contractor to take corrective action or employ other remedies for non-compliance as authorized in the *Contract Non-Compliance* section in the event LDH determines the Contractor's rate of out-of-state placements to be excessive.

2.9.25.26 The Contractor shall develop policies and procedures to support the development of a workforce and provide services to the dually diagnosed, individuals with a co-occurring developmental disability and mental health diagnosis. These policies and procedures shall include:

2.9.25.26.1 A plan for how to improve and increase services available for individuals with behavioral health and developmental disabilities, including autism spectrum disorders, which incorporates reducing health disparities and long-range fiscal planning to support the training and fiscal sustainability of the provision of such services. This shall be submitted to LDH or its designee as part of Readiness Review for approval and annually thereafter.

2.9.25.26.2 An annual assessment of the number of providers serving Enrollees with behavioral health and developmental disabilities and of whether the needs of this population are being met. This assessment shall include: the number of Enrollees being served out-of-state due to a lack of appropriate services in state; whether these providers have waiting lists; and whether access to care standards are being met by these providers.

2.9.25.26.3 A database of trainers, consultants, and contractors that specialize in working with Enrollees with dual diagnosis of behavioral health and developmental disabilities.

2.9.25.26.4 Training plans and curricula that address dual diagnosis. Training on dual diagnosis shall be offered to behavioral health Network Providers who are interested in certification and required for unlicensed staff working with this population. The training program and approach shall be reviewed and subject to approval by OBH and OCDD.

2.9.25.26.5 Incentives for providers to attain the certification.

2.9.25.27 The Contractor shall contract with at least one (1) psychiatric residential treatment facility (PRTF) within the State with the ability to work effectively with Enrollees with dual diagnosis of developmental disabilities and behavioral health. The Contractor shall have at least one (1) Therapeutic Group Home (TGH) within the State with the ability to work effectively with Enrollees with dual diagnosis of developmental disabilities and behavioral health.

2.9.25.28 The Contractor shall have community providers (i.e. psychiatrist, psychologist, social workers, advanced practice registered nurses [APRNs], mental health rehabilitation [MHR] providers, Wrap-around

agencies [WAAs], etc.) within the State with the ability to effectively work with Enrollees with a dual diagnosis of developmental disabilities and behavioral health.

2.9.25.29 The Contractor shall make training available to licensed providers as needed to improve and increase access to behavioral health services for this population. The training program and approach must be reviewed and subject to approval by OBH and OCDD.

2.9.25.30 Unlicensed staff shall mandatorily complete training that addresses dual diagnosis and shall receive certification.

2.9.25.31 The Contractor must complete all necessary agreements with the LCH needed in order to ensure collaboration in congruence with the DOJ Compliance Guide. This includes but is not limited to Data Sharing and Master User Agreements as well as Memoranda of Understanding.

2.9.25.32 After receiving notification from a crisis service provider or the LCH, the Contractor shall assist in coordinating outpatient follow-up appointments to support connection to ongoing care following a crisis episode.

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2.9.26 Indian Health Care Providers (IHCPs)

2.9.26.1 The Contractor shall demonstrate that there are sufficient IHCPs participating in the provider network of the Contractor to ensure Timely access to services available under the Contract from such providers for Indian Enrollees who are eligible to receive services.

2.9.26.2 The IHCPs, whether participating in the Contractor network or not, shall be paid for MCO Covered Services provided to Indian Enrollees who are eligible to receive services from such providers as follows:

2.9.26.2.1 At a rate negotiated between the Contractor and the IHCP; or

2.9.26.2.2 In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the Contractor would make for the services to a Network Provider which is not an IHCP; and

2.9.26.2.3 Make payment to all IHCPs in its network in a Timely manner as required for payments to practitioners in individual or group practices under 42 CFR §447.45 and §447.46.

2.9.26.3 The Contractor shall permit any Indian who is enrolled with the Contractor and is eligible to receive services from an IHCP primary care provider participating as a Network Provider, to choose that IHCP as his or her PCP, as long as that provider has capacity to provide the services.

2.9.26.4 The Contractor shall permit Indian Enrollees to obtain MCO Covered Services from out-of-network IHCPs from whom the Enrollee is otherwise eligible to receive such services.

2.9.26.5 Where Timely access to MCO Covered Services cannot be ensured due to few or no IHCPs, the Contractor shall be considered to have met the requirement in paragraph 42 CFR §438.14(b)(1) if:

2.9.26.5.1 Indian Enrollees are permitted by the Contractor to access out-of-state IHCPs; or

2.9.26.5.2 If this circumstance is deemed to be good cause for Disenrollment from the Managed Care Program in accordance with 42 CFR §438.56(c).

2.9.26.6 The Contractor shall permit an out-of-network IHCP to refer an Indian Enrollee to a Network Provider.

2.9.27 Network Development and Management Plan

2.9.27.1 The Contractor shall develop and maintain a Network Development and Management Plan which ensures that MCO Covered Services are reasonably accessible to Enrollees and are provided promptly in accordance with the urgency of the situation and the accessibility standards in this Contract.

2.9.27.2 The Contractor shall submit its Network Development and Management Plan in accordance with the **MCO Manual** to LDH or its designee during Readiness Review and as requested by LDH.

2.9.27.3 The Network Development and Management Plan shall include the Contractor's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access to all required services included in the Contract. When designing the network of providers, and entering into Network Provider Agreements, the Contractor shall consider the number of individuals enrolled in the Louisiana Medicaid Program; the expected utilization of services; the characteristics of specific populations included in this Contract; the number and types of providers required to furnish services; the number of contract providers who are not accepting new Enrollees; the geographic location of providers and Enrollees; distance, and the means of transportation ordinarily used by Enrollees; and whether a provider location provides physical access for Enrollees with disabilities.

2.9.28 Material Change to Provider Network

2.9.28.1 The Contractor shall provide advance written notice to LDH prior to any Network Provider Agreement termination that causes a Material Change in the Contractor's provider network, whether terminated by the Contractor or the provider, and such notice shall include the reason(s) for

the proposed action. The notification shall include the Contractor's plans to notify Enrollees of such change and the strategy to ensure Timely access through other in-network and/or out-of-Network Providers to prevent stoppage or interruption of services to the Enrollee.

2.9.28.2 A Material Change for purposes of the Provider Network is defined as one which affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance and network standards as described in the Contract, including but not limited, to the following:

2.9.28.2.1 A termination or non-renewal of a hospital or residential treatment facility;

2.9.28.2.2 A termination or non-renewal of an Opioid Treatment Program;

2.9.28.2.3 A termination or non-renewal of community health center or community mental health center;

2.9.28.2.4 A termination or non-renewal of a chain pharmacy within the Contractor's network;

2.9.28.2.5 A change to one (1) of the Contractor's Material Subcontractors, including its behavioral health Subcontractor, if applicable;

2.9.28.2.6 Any change that would cause more than five percent (5%) of Enrollees within the parish to change the location where services are received or rendered;

2.9.28.2.7 A decrease in the total of individual PCPs by more than five percent (5%);

2.9.28.2.8 A loss of any participating specialist which may impair or deny an Enrollee's adequate access to providers;

2.9.28.2.9 A decrease in a behavioral health provider type by more than five percent (5%);

2.9.28.2.10 A loss of any participating behavioral health specialist which may impair or deny the Enrollee's adequate access to providers; or

2.9.28.2.11 Other adverse changes to the composition of the Contractor's network which result in the Contractor's inability to meet the network adequacy and Timely access to care standards of this Contract or which impair or deny an Enrollee's adequate access to providers such as capping of patient loads by Network Providers impacting availability of qualified specialists in a region.

2.9.28.3 The Contractor shall provide or arrange for medically necessary MCO Covered Services if the network becomes temporarily insufficient within a service area.

2.9.28.4 The Contractor shall submit required information on Material Changes to its provider network in accordance with the **MCO Manual** in the time period specified by LDH.

2.9.29 Network Provider Agreement Requirements

2.9.29.1 The Contractor shall enter into written agreements with providers to provide MCO Covered Services.

2.9.29.2 In order to ensure that Enrollees have access to a broad range of health care providers, and to limit the potential for Disenrollment due to lack of access to providers or services, the Contractor shall not have a contractual arrangement with any service provider in which the provider represents or agrees that it shall not contract with another MCO or in which the Contractor represents or agrees that it shall not contract with another provider. The Contractor shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.

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

2.9.29.4 The Contractor shall provide LDH or its designee with written provider credentialing and re-credentialing policies that are compliant with NCQA Health Plan Accreditation standards and all applicable Federal and State laws, regulations, rules, policies, procedures, and manuals as part of Readiness Review and on an annual basis.

2.9.29.5 The Contractor's provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

2.9.29.6 The Contractor shall not include in its Network Provider Agreements an all-products clause, requiring providers to participate in all products offered by the Contractor or its parent organization.

2.9.29.7 The Contractor shall inform all providers, at the time they enter into a contract, about the Enrollees' rights, and the availability of assistance, to file Grievances and Appeals, request State Fair Hearings, and request continuation of benefits that the Contractor seeks to reduce or terminate during an Appeal or State Fair Hearing, if filed within the allowable timeframes, although the Enrollee may be liable for the cost of any continued benefits while the Appeal or State Fair Hearing is pending if the final decision is adverse to the Enrollee.

2.9.29.8 The Contractor shall require that providers not bill Enrollees for MCO Covered Services in any amount greater than would be owed if the Contractor provided the services directly.

2.9.29.9 The Contractor shall require that providers offer the same services to Enrollees as those offered to individuals not receiving services through the Louisiana Medicaid Program, provided that they are MCO Covered Services. Providers shall also be required to treat Enrollees equally in

terms of scope, quality, duration, and method of delivery of services, unless specifically limited by regulation. Providers are not required to accept every Enrollee requesting service.

2.9.29.10 The Contractor shall require the provider to report to the Contractor loss of accreditation, suspension, or action taken that could result in loss of accreditation, inclusive of all documentation from the accrediting body, within twenty (24) hours of receipt of notification, if required to be accredited.

2.9.29.11 The Contractor shall require the provider to immediately report cancellation of any required insurance coverage, licensure, or certification to the Contractor.

2.9.29.11.1 Upon receipt of this report, the Contractor shall immediately notify the Provider that it is prohibited from performing any work under the Contract unless and until the Provider provides written documentation to the Contractor indicating that the Provider has reinstated all required insurance coverage, licensure, or certification.

2.9.29.12 As required by 42 CFR §438.3(k) and §438.230, the Contractor shall be responsible for overseeing all providers' performance and shall be held accountable for any function and responsibility that it delegates to any provider, including, but not limited to:

2.9.29.12.1 All Network Provider Agreements must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the agreement;

2.9.29.12.2 All Network Provider Agreements shall require the provider to comply with all applicable Contract requirements, applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, Waivers, and subregulatory guidance;

2.9.29.12.3 Prior to executing a Network Provider Agreement, the Contractor shall evaluate the prospective provider's qualifications and ability to perform the activities to be delegated; and

2.9.29.12.4 The Contractor shall develop a template for Network Provider Agreements that shall be approved by LDH in writing that specifies the requirements and reporting responsibilities delegated to the provider and provides for revoking delegation or imposing other non-compliance actions and penalties if the provider's performance is inadequate.

2.9.29.13 The Contractor shall require providers of personal care services (PCS) and home health care services to use the State-contracted electronic visit verification (EVV) system as directed by LDH.

2.9.29.14 The Network Provider Agreement shall require providers to provide any information related to the performance of contract responsibilities as requested by LDH. The Contractor shall be responsible for forwarding the information received from providers to LDH.

2.9.29.15 The contractor shall submit all original and amended Network Provider Agreement templates to LDH for approval prior to the execution of the agreement with a provider.

2.9.29.16 All Network Provider Agreements shall provide that the provider shall comply, within a reasonable time, with any information, records or data requests from any healthcare oversight agency, including the Louisiana Department of Justice, MFCU, related to any services provided under this Contract. When requested by the MFCU, the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The provider shall agree that its Network Provider Agreement creates for any healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

2.9.29.17 All Network Provider Agreements with hospitals, shall include a requirement for the development of a discharge plan, with an aftercare appointment with a behavioral health provider as soon as clinically indicated but not later than ten (10) Calendar Days from the date of discharge, for Enrollees with behavioral health-related hospitalizations unless there is documented Enrollee refusal. This requirement shall be included in all present and future Network Provider Agreements and may be incorporated through a separate addendum to the agreement. In addition, the Network Provider Agreement shall specify the Contractor's responsibility as it pertains to discharge planning, including securing post-discharge appointments and linkages, and include information on the availability of a dedicated MCO e-mail address and telephone number for hospitals to utilize for Care Coordination activities.

2.9.30 Credentialing and Re-credentialing of Providers and Clinical Staff

2.9.30.1 The Contractor shall have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230, and §438.602(b) and NCQA Health Plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the Contractor selects and directs its Enrollees to see a specific provider or group of providers. These procedures shall be submitted to LDH or its designee during Readiness Review, and subsequently any time a change is made, and annually thereafter by contract year.

2.9.30.2 The Contractor shall develop and implement policies and procedures for the acceptance of new providers screened, enrolled, and approved in

writing by the State, and termination or suspension of providers to ensure compliance with the Contract.

2.9.30.3 Prior to entering into a Network Provider Agreement, the Contractor shall ensure that providers have been properly credentialed to ensure provider facilities, organizations, and staff meet all qualifications and requirements for participation in the Louisiana Medicaid Program and as outlined in the **MCO Manual**.

2.9.30.4 The Contractor shall use the Louisiana Standardized Credentialing Application Form (see **MCO Manual**) or Council for Affordable Quality Healthcare (CAQH) standardized credentialing form. The Contractor must allow providers to use CAQH if available for their provider type.

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

2.9.30.6 If the Contractor has or is pursuing NCQA Health Plan Accreditation, those credentialing policies and procedures shall meet LDH's credentialing requirements.

2.9.30.7 The Contractor shall completely process credentialing applications from all provider types within sixty (60) Calendar Days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed Network Provider Agreement, complying with La. R.S. 46:460.61. "Completely process" means that the Contractor shall:

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2.9.30.7.1 Provide written confirmation, electronically or by mail, of receipt to the provider within five (5) Business Days of receipt of the application;

2.9.30.7.2 If the application is deemed incomplete, send a written request within thirty (30) Calendar Days of receipt of the application to the provider for all missing information;

2.9.30.7.3 Review, approve and load approved applicants to its provider files in its Claims processing system;

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2.9.30.7.4 Comply with the provider notice requirements in accordance with La. R.S. 46:460.72(A) and

2.9.30.7.5 Submit on the weekly electronic Provider Directory to LDH or LDH's designee; or

2.9.30.7.6 Deny the application, notifying the provider of the adverse determination, and assure that the provider is not used by the Contractor.

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2.9.30.8 The Contractor shall comply with interim credentialing requirements in accordance with La. R.S. 46:460.62.

2.9.30.9 Notwithstanding the above, the Contractor shall consider providers who maintain hospital privileges or are members of the medical staff of a hospital, FQHC, or RHC to have satisfied, and be otherwise exempt from having to satisfy, any credentialing requirements of the Contractor, in accordance with La. R.S. 46:460.61. The Contractor shall verify that these providers satisfy the exemption criteria and load them to its provider files and into its Claims processing system within thirty (30) Calendar Days of receipt of documentation supporting the exemption. The Contractor shall track the providers who were credentialed by a hospital, FQHC, or RHC, including the expiration or termination of privileges and/or employment. Prior to expiration or upon notice of termination, such that the provider no longer maintains any hospital privileges and is no longer a member of the medical staff of any hospital, FQHC, or RHC, the Contractor shall follow its standard process for credentialing a new provider. This exemption does not remove the Contractors obligation to screen providers for exclusions prior to contracting and on a regular basis in accordance with the interval specified in the Contract.

2.9.30.10 If the Contractor has delegated credentialing to a Subcontractor, there shall be a written description of the delegation of credentialing activities within the contract. The Contractor must require that the Subcontractor provide assurance that all licensed medical professionals are credentialed in accordance with LDH's credentialing requirements.

2.9.30.11 The Contractor shall not delegate credentialing of specialized behavioral health providers except as allowed by La. R.S. 46:460.61 or approved by LDH in writing in advance.

2.9.30.12 To the extent the Contractor has delegated credentialing agreements in place with any delegated credentialing agency approved by LDH in writing, the Contractor shall ensure all providers submitted to the Contractor from the delegated credentialing agent are loaded to its provider files and into its Claims processing system within thirty (30) Calendar Days of receipt.

2.9.30.13 The Contractor shall notify LDH when it denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

2.9.30.14 The process of periodic re-credentialing shall be completed at least once every three (3) years. The MCO shall comply with the provider notice requirements in accordance with La. R.S. 46:460.72(B).

2.9.30.15 The Contractor shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with the Contract. The policies and procedures should

include, but are not limited to, the encouragement of applicable board certification(s).

2.9.30.16 The Contractor shall develop and implement a mechanism, subject to LDH approval, for reporting quality deficiencies, which result in suspension or termination of a Network Provider. This process shall be submitted to LDH or its designee as part of Readiness Review and annually thereafter, and prior to implementation of revisions.

2.9.30.17 The Contractor shall designate a credentialing committee that uses a peer review process to evaluate provider credentialing files (including re-credentialing files). The credentialing committee, including the Medical Director, is responsible for credentialing decisions and is required to document its steps in the decision process and maintain individual provider files.

2.9.30.18 LDH reserves the right to contract with a single National Committee for Quality Assurance (NCQA)-certified Credential Verification Organization (CVO). If this option is pursued, the Contractor and its Subcontractors shall agree to use the CVO for the credentialing and re-credentialing of all Network Providers. The Contractor will be given at least ninety (90) Calendar Days' notice before implementation of any CVO contract. When LDH implements a CVO, the Contractor shall:

2.9.30.18.1 Accept the final credentialing decisions of the CVO.

2.9.30.18.2 Within thirty (30) Calendar Days of receipt of an approved credentialing decision, load providers in its Claims processing system.

2.9.30.18.3 Provide information to the State's provider management contractor on Network Providers.

2.9.30.18.4 Participate on the CVO's Credentialing Committee to evaluate provider credentialing files (including re-credentialing files) using a peer review process. The credentialing committee is responsible for credentialing decisions which shall be accepted by the Contractor.

2.9.31 Network Guidelines for Providers Needing DCFS Licensing

It is the Contractor's responsibility to ensure its providers comply with DCFS licensing requirements as applicable and can submit proof of compliance upon request. The Contractor shall follow communication protocols as established by DCFS if necessary.

2.9.32 Provider-Enrollee Communication Anti-Gag Clause

2.9.32.1 Subject to the limitations described in 42 CFR §438.102(a)(2), the Contractor shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of an Enrollee, who is a patient of the provider, regardless of

whether benefits for such care or treatment are provided under the Contract, for the following:

2.9.32.1.1 The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

2.9.32.1.2 Any information the Enrollee needs in order to decide among relevant treatment options;

2.9.32.1.3 The risks, benefits and consequences of treatment or non-treatment; and

2.9.32.1.4 The Enrollee's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.

2.9.32.2 Any Contractor that violates the anti-gag provisions set forth in 42 CFR §438.102(a)(1) shall be subject to intermediate sanctions.

2.9.32.3 The Contractor shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice given to Enrollees, including interference with provider's advice to Enrollees and information disclosure requirements related to physician incentive plans.

2.9.33 Pharmacy Network, Access Standards, and Reimbursement

2.9.33.1 The Contractor shall provide a pharmacy network that complies with the requirements of this Contract and the **MCO Manual**. At a minimum, the Contractor's pharmacy network shall include only licensed and registered pharmacies who are appropriately screened by and enrolled with the State and that conform to the Louisiana Board of Pharmacy rules concerning the records to be maintained by a pharmacy.

2.9.33.2 The Contractor shall not prohibit any pharmacy or pharmacist participating in the Louisiana Medicaid Program from contracting as a Network Provider provided the pharmacy or pharmacist is licensed and in good standing with the Louisiana State Board of Pharmacy and accepts the terms and conditions of the contract offered to them by the Contractor.

2.9.34 Out-of- State Pharmacy Providers

2.9.34.1 If services are provided to an Enrollee who is out-of-state, the Contractor shall require the provider to enroll in the Louisiana Medicaid Program for the purposes of securing payment of the Claim and finalizing the Claim at issue, not for obtaining continuous and active Network Provider status. The Contractor may include out-of-state pharmacies that supply services not available within the State as a Network Provider.

2.9.34.2 The Contractor shall have a network pharmacy audit program that includes, at a minimum:

2.9.34.2.1 Random audits to determine provider compliance with the policies, procedures and limitations outlined in the Network Provider Agreement and this Contract. The Contractor shall not utilize contingency fee based pharmacy audits.

2.9.34.2.2 The Contractor shall submit to LDH or its designee the policies of its audit program for approval during Readiness Review.

2.9.34.3 The Contractor shall ensure that pharmacies submit the NPI of the prescriber on all pharmacy Claims. The Contractor shall deny Claims submitted without the NPI of the prescriber.

2.9.34.4 The Contractor shall educate Network Providers on how to access the PDL on their websites. The Contractor shall also provide provider education on pharmacy Claims processing and payment policies and procedures.

2.9.34.5 In accordance with applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, and Waivers, the Contractor may negotiate the ingredient cost reimbursement in its contracts with providers. However, the Contractor shall:

2.9.34.5.1 Reimburse no less than the FFS Rate on the date of service to all local pharmacies as required by La. R.S. 46:460.36(D);

2.9.34.5.2 Reimburse any state imposed provider fees for pharmacy Claims, on top of the professional dispensing fee and ingredient cost reimbursement;

2.9.34.5.3 Update the ingredient costs of medications at least weekly and within three (3) Business Days of new rates being posted from the national database source selected by the Contractor;

2.9.34.5.4 Base Maximum Allowable Cost (MAC) price lists on generic drugs with a FDA rating beginning with an "A";

2.9.34.5.5 Make the drug pricing list available to pharmacies for review, upon request; and

2.9.34.5.6 Afford individual pharmacies a chance to Appeal inadequate reimbursement.

2.9.34.6 The Contractor and the Contractor's PBM shall not charge pharmacy providers Claims processing or provider Enrollment fees. This Section does not prohibit sanctioning pharmacy providers.

2.9.34.7 Pharmacy Claims Dispute Management

The Contractor shall maintain a Claims dispute process to permit pharmacies to dispute the reimbursement paid for any Claim made for the dispensing of a drug as specified in the **MCO Manual**.

2.9.34.8 Mail Order/Mail Service Pharmacy

The Contractor shall not require its Enrollees to use a mail service pharmacy. Mail order shall not exceed more than one percent (1%) of all pharmacy Claims. Enrollees shall not be charged any amounts above applicable copays for mail order (e.g. shipping and handling fees).

2.9.34.9 Specialty Drugs and Specialty Pharmacies

2.9.34.9.1 LDH recognizes the importance of providing adequate access to specialty drugs to Enrollees while ensuring proper management of handling and utilization. The Contractor shall comply with the specialty drug and specialty pharmacy requirements specified in the **MCO Manual** and this Contract.

2.9.34.9.2 A specialty drug is defined as a prescription drug which meets three (3) or more of the following criteria:

2.9.34.9.2.1 The drug is not routinely dispensed at a majority of retail community pharmacies due to physical or administrative requirements that limit preparation and/or delivery in the retail community pharmacy environment. Such drugs may include, but are not limited to, chemotherapy, radiation drugs, intravenous therapy drugs, biologic prescription drugs approved for use by the FDA, and/or drugs that require physical facilities not typically found in a retail community pharmacy, such as a ventilation hood for preparation;

2.9.34.9.2.2 The drug is used to treat complex, chronic, or rare medical conditions:

That can be progressive; or

That can be debilitating or fatal if left untreated or undertreated; or

For which there is no known cure.

2.9.34.9.2.3 The drug requires special handling, storage, and/or has distribution and/or inventory limitations;

2.9.34.9.2.4 The drug has a complex dosing regimen or requires specialized administration;

2.9.34.9.2.5 Any drug that is considered to have limited distribution by the FDA;

2.9.34.9.2.6 The drug requires:

Complex and extended patient education or counseling; or

Intensive monitoring; or

Clinical oversight; and

2.9.34.9.2.7 The drug has significant side effects and/or risk profile.

2.10 Provider Services and Support

2.10.1 Provider Advisory Council

The Contractor shall establish a Provider Advisory Council to provide input and advice to enhance the Contractor's service delivery, improve provider satisfaction and Enrollee experience, promote data sharing and value-based payment strategies, and enable regular provider participation in clinical policy development and provider operations.

2.10.2 Provider Directory

2.10.2.1 The Contractor shall maintain a complete and accurate provider directory as required in the *Enrollee Services* section to be utilized by its Network Providers.

2.10.2.2 The Contractor shall make available to all PCPs a listing of referral providers, including behavioral health providers, in hard copy if requested. The Contractor shall also maintain an updated electronic, web-accessible version of the referral provider listing.

2.10.3 Provider Relations

The Contractor shall:

2.10.3.1 Establish and maintain a formal provider relations function to respond Timely and adequately to inquiries, questions, and concerns from Network Providers;

2.10.3.2 Provide sufficient information and procedural guidelines to all providers in order to operate in full compliance with this Contract and all applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, and Waivers;

2.10.3.3 Provide sufficient information and procedural guidelines to all providers that address services excluded or limited by the Louisiana Medicaid Program;

2.10.3.4 Maintain a protocol that facilitates communication to and from providers and the Contractor, and which shall include, but not be limited to, a provider newsletter, e-mail, periodic provider meetings, and updated contact information for Provider Relations representatives that includes their areas of responsibility;

2.10.3.5 Except as otherwise required or authorized by LDH in writing or by operation of law, ensure that providers receive thirty (30) Calendar Days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect;

2.10.3.6 Work in collaboration with providers to actively improve the quality of care provided to Enrollees, consistent with the quality improvement goals and quality measures, and all other requirements of this Contract;

2.10.3.7 Have trained provider relations staff dedicated to this Contract and available to providers to address provider issues Monday through Friday from 7 a.m. to 7 p.m. Central Time and to handle non-routine Prior Authorization requests twenty-four (24) hours per day seven (7) days per week;

2.10.3.8 Have a process in place to handle after-hours inquiries from providers seeking to verify Enrollment for an Enrollee in need of urgent or Emergency Services. The Contractor and its providers shall not require such verification prior to providing Emergency Services;

2.10.3.9 Handle emergency provider issues twenty-four (24) hours per day seven (7) days per week;

2.10.3.10 Provide ongoing provider training, respond to provider inquiries and provide general assistance to providers regarding program operations and requirements; and

2.10.3.11 Ensure regularly scheduled visits to provider sites, as well as ad hoc visits as circumstances dictate and provide technical assistance, including assistance on the Contractor's systems and billing practices. Documentation of these visits shall be provided upon request by LDH and shall include sign-in sheets, agendas, documented follow-up action items (as appropriate), and any distributed materials.

2.10.3.12 Establish and maintain a process whereby hospitals may readily obtain assistance, including accurate contact information, regarding behavioral

health Network Providers who may accept aftercare appointments within ten (10) Calendar Days of the discharge date for Enrollees presenting with behavioral health needs. This shall include, but is not limited to the following:

2.10.3.12.1 Establishment of a dedicated MCO e-mail address and toll-free telephone number, available and monitored twenty-four (24) hours a day, seven (7) days a week by MCO staff, for hospitals to request assistance with locating behavioral health providers in the Enrollee's area who will accept an aftercare appointment within ten (10) days of the Enrollee's discharge date and other Care Coordination activities. The telephone number must be answered by a live voice and include immediate handoff to an MCO staff member with detailed knowledge regarding Louisiana Medicaid-funded behavioral health services and Network Providers with possible appointment availability within ten (10) Calendar Days of the Enrollee's discharge date.

2.10.3.12.2 Development and maintenance of a listing of verified behavioral health Network Providers in each parish, if possible, or region, who may accept an aftercare appointment within ten (10) Calendar Days of the Enrollee's discharge date, which shall be provided to hospitals upon request.

2.10.3.12.3 Documentation of all requests received through the dedicated e-mail address and telephone number including information on any requests that were not responded to by the Contractor within three (3) hours, any instances in which an appointment could not be secured within ten (10) Calendar Days of the Enrollee's discharge date, and failed attempts by service type. This information shall be provided to LDH upon request, utilized by the Contractor to update provider files (e.g., provider closures, providers not accepting new appointments), assess network adequacy, and be integrated into the Contractor's Network Development and Management Plan Strategy.

2.10.4 Provider Toll-Free Telephone Line

2.10.4.1 The Contractor shall operate a provider toll-free telephone line to respond to provider questions, comments and inquiries. The telephone line shall include the ability for providers to access interpreter services as described in the *Enrollee Services* section. The telephone line shall have the capability to track provider call management metrics and comply with the Enrollee call center performance standards outlined in the *Enrollee Services* section.

2.10.4.2 The Contractor shall develop telephone line procedures that address the hiring and training of personnel, staffing ratios, hours of operation, response standards, monitoring of calls via recording or other means, and compliance with this Contract's standards.

2.10.4.3 Outside of Business Hours, the provider service component of the telephone line shall include the capability of providing information regarding Business Hours and instructions for verifying enrollment for any Enrollee with an emergency or urgent medical condition.

2.10.5 Provider Website

2.10.5.1 The Contractor shall have a provider website. The provider website may be developed on a page within the Contractor's existing website (such as a portal) to meet these requirements. Requirements for the website are contained in the **MCO Manual**.

2.10.5.2 The Contractor shall maintain forms on its provider website to allow submittal of complaints, disputes, Grievances, and Appeals electronically. In addition, the Contractor shall provide providers with an address to submit Grievances and Appeals in writing and a phone number to submit Grievances and Appeals by telephone.

2.10.5.3 The Contractor's provider website shall provide a secure provider portal in accordance with the following requirements:

2.10.5.3.1 The Contractor shall comply with State and Federal standards and procedures (e.g., HL7, HIPAA, CMS, CPT, ICD-10, and DSM-5) for all provider used systems and maintain a uniform service and provider taxonomy for billing and information management purposes;

2.10.5.3.2 The Contractor shall, with appropriate Enrollee consent, allow the provider access to Enrollee clinical data including assessments and plans of care and/or relevant data necessary to provide for appropriate coordination of care;

2.10.5.3.3 The Contractor shall grant user-defined LDH access to and training on the provider website; and

2.10.5.3.4 The Contractor shall provide a link to the Medicaid Behavioral Health Services Provider Manual and the Contractor's provider handbook.

2.10.5.4 The Contractor shall provide, in accordance with national standards, Claims inquiry information to providers and Subcontractors via the Contractor's website.

2.10.5.5 The Contractor shall develop and maintain methods to communicate policies, procedures and relevant information to providers through its website.

2.10.5.6 The Contractor shall provide all qualified behavioral health service providers access to the Medicaid Behavioral Health Services Provider Manual, and any updates, either through the Contractor's website, or by providing paper copies to providers upon request.

2.10.5.7 The Contractor shall remain compliant with the HIPAA Privacy and Security Rules when providing any Enrollee eligibility or member identification information on the website.

2.10.5.8 The Contractor website shall comply with Section 508 of the ADA, and meet all standards the ADA sets for people with visual impairments and disabilities that make usability a concern.

2.10.5.9 The Contractor is responsible for ensuring that the website is maintained with accurate and current information and is compliant with requirements of this Contract.

2.10.6 Provider Handbook

2.10.6.1 The Contractor shall develop and maintain a provider handbook which includes specific information about MCO Covered Services, non-MCO Covered Services, and other requirements of the Contract relevant to provider responsibilities.

2.10.6.2 The Contractor shall submit to LDH or its designee for approval as part of Readiness Review a provider handbook specific to the Managed Care Program.

2.10.6.3 The Contractor shall submit an updated provider handbook to LDH annually and as requested by LDH. Requirements for the provider handbook are located in the **MCO Manual**.

2.10.6.4 The Contractor shall distribute a provider handbook to all providers at the time Network Provider Agreements are executed and annually as the provider handbook is updated.

2.10.6.5 The Contractor may choose not to distribute a hard copy of the provider handbook, provided it submits a written notification to all providers that explains how to obtain the provider handbook from the Contractor's website. This notification shall also detail how the provider can request a hard copy from the Contractor at no charge to the provider. All provider handbooks and bulletins shall comply with applicable Federal and State laws, regulations, rules, policies, procedures, and manuals. The provider handbook shall serve as a source of information regarding MCO Covered Services, policies and procedures, laws, regulations, telephone access, and special requirements to ensure all Contract requirements are met.

2.10.6.6 The Contractor shall disseminate bulletins as needed to incorporate any changes to the provider handbook.

2.10.7 Provider Education and Training

2.10.7.1 The Contractor shall provide training to all providers and their staff regarding the requirements of the Contract, including limitations on provider Marketing, and identification of special needs of Enrollees. The Contractor shall conduct initial training within thirty (30) Calendar Days of placing a new Network Provider, or provider group, on active status. The Contractor shall also conduct ongoing training, as deemed necessary by

the Contractor or LDH, in order to ensure compliance with program standards and the Contract.

2.10.7.2 The Contractor shall submit a copy of the Provider Training Manual and training schedule to LDH or its designee for approval as part of Readiness Review. Any changes to the manual shall be submitted to LDH at least thirty (30) Calendar Days prior to the scheduled change and dissemination of such change.

2.10.7.3 The Contractor shall develop and offer specialized initial and ongoing training in the areas including, but not limited to, billing procedures and Service Authorization requirements.

2.10.7.4 The Contractor shall provide prescriber education, training and outreach to support the implementation, maintenance, and updating of its behavioral health pharmacy management activities, including, but not limited to, education and training relative to the Preferred Drug List, Prior Authorization requirements, fail first, step-therapy, approved prescribing caps, and relevant Enrollee Appeal, expedited Appeal, and peer-to-peer procedures and protocols. The Contractor shall submit its tentative prescriber training and education schedule or plan to LDH or its designee as part of Readiness Review for approval.

2.10.7.4.1 The Contractor must obtain prior written approval from LDH for all provider materials related to the pharmacy benefit, unless exempted by LDH in writing. Provider (pharmacy and prescribing) materials must be submitted to LDH for approval at least thirty (30) Calendar Days before implementation, unless the Contractor can demonstrate to LDH's satisfaction that just cause for an abbreviated timeframe exists.

2.10.7.5 The Contractor shall provide technical assistance and network development training (e.g., billing, behavioral health services and authorization, linguistic/cultural competency, etc.) for its behavioral health providers, including required trainings for certain behavioral health providers (e.g. Child and Adolescent Needs and Strengths [CANS], Level of Care Utilization System [LOCUS], OBH standardized training for non-licensed providers, etc.). The Contractor shall maintain records of such training including completion dates, which shall be made available to LDH upon written request.

2.10.7.6 The Contractor shall offer provider trainings on integrated care including, but not limited to, appropriate utilization of basic behavioral health screens in the primary care setting and basic physical health screenings in the behavioral health setting.

2.10.7.7 The Contractor shall ensure that behavioral health providers (i.e. organizations, practitioners and staff) are trained and/or meet training requirements in accordance with State laws, regulations, rules, policies, and the **MCO Manual** for MCO Covered Services.

2.10.7.8 LDH shall be allowed to attend all provider training sessions upon request. The Contractor shall maintain and provide upon LDH written request all provider training reports identifying training topics, dates, sign-in sheets, invited/attendees' lists, and organizations trained, as applicable.

2.10.8 Provider Satisfaction Surveys

2.10.8.1 The Contractor shall conduct an annual provider survey to assess overall satisfaction, as well as satisfaction with the following functions:

2.10.8.1.1 Access to linguistic assistance;

2.10.8.1.2 Provider Enrollment;

2.10.8.1.3 Provider communication;

2.10.8.1.4 Provider education and trainings (including cultural competency trainings);

2.10.8.1.5 Resolution to provider complaints/disputes;

2.10.8.1.6 Claims processing;

2.10.8.1.7 Claims reimbursement;

2.10.8.1.8 Network/coordination of care;

2.10.8.1.9 Utilization management processes (including medical reviews and support toward Patient Centered Medical Home implementation); and

2.10.8.1.10 NEMT services.

2.10.8.2 The Provider Satisfaction survey tool and methodology must be submitted to LDH for approval ninety (90) Calendar Days prior to administration.

2.10.8.3 All required components of the survey tool must be administered and results must be reported to LDH annually within the provider satisfaction survey report. Survey response rates shall consider the population size and demographic category of providers with a minimum margin of error of plus or minus five percent (5%) and a confidence level of at least ninety-five (95%). This shall be the minimum response rated for surveys completed and reported to LDH.

2.10.8.4 The Contractor shall submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings, includes the raw data in the format required by LDH, and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due one hundred twenty (120) Calendar Days after the end of the contract year.

2.10.9 Provider Complaint System

2.10.9.1 Definition of Provider Complaint

For the purposes of this subsection, a provider complaint is any verbal or written expression, originating from a provider and delivered to any employee of the Contractor, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by the Contractor, including, but not limited to, an adverse action, excluding request of reconsideration or Appeal for specific individual Claims. It does include general complaints about Claim payment policies. Grievances and Appeals filed by providers on behalf of an Enrollee should be documented and processed in accordance with Enrollee Grievance and Appeals policies.

2.10.9.2 The Contractor shall establish a Provider Complaint System to track the receipt and resolution of provider complaints from in-network and out-of-Network Providers.

2.10.9.3 Definition of Adverse Action

For the purposes of this subsection, an adverse action is defined as:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The failure to provide services in a Timely manner, as defined in this section; or
- The failure of the MCO to act within the timeframes provided in this Contract.

2.10.9.4 This system must be capable of identifying and tracking provider complaints received by phone, in writing, or in person.

2.10.9.5 As part of the Provider Complaint system, the Contractor shall:

2.10.9.5.1 Have dedicated provider relations staff for providers to ask questions, file a provider complaint and resolve problems;

2.10.9.5.2 Identify a key staff person specifically designated to receive and process provider complaints;

2.10.9.5.3 Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and Network Provider Agreement provisions, collecting all pertinent facts from all parties and applying the Contractor's written policies and procedures; and

2.10.9.5.4 Ensure that the Contractor's executives with the authority to require corrective action are involved in the provider complaint escalation process. The Contractor shall provide the names, phone numbers and e-mail addresses of these executives to LDH or its designee during Readiness Review and within two (2) Business Days of any changes.

2.10.9.6 The Contractor shall develop and implement written policies and procedures which detail the operation of the Provider Complaint System and align with the provider issue resolution requirements in the **MCO Manual**. The Contractor shall submit its Provider Complaint System policies and procedures to LDH or its designee for approval as part of Readiness Review.

2.10.9.7 The Contractor shall acknowledge provider complaints within three (3) Business Days of receipt and shall resolve complaints and/or communicate the result to the provider as soon as possible or within thirty (30) Calendar Days of receipt, whichever is sooner.

2.10.9.8 The policies and procedures shall include, at a minimum:

2.10.9.8.1 A process to allow providers to file a written complaint and a description of how providers can file complaints with the Contractor and the resolution time;

2.10.9.8.2 A description of how and under what circumstances providers are advised that they may file a complaint with the Contractor;

2.10.9.8.3 A description of how provider relations staff are trained to distinguish between a provider complaint and an Enrollee Grievance or Appeal in which the provider is acting on the Enrollee's behalf;

2.10.9.8.4 A process to allow providers to consolidate complaints of multiple Claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment Claims are included in the bundled complaint;

2.10.9.8.5 A process for thoroughly investigating each complaint and for collecting pertinent facts from all parties during the investigation;

2.10.9.8.6 A description of the methods used to ensure that the Contractor's executive staff with the authority to require corrective action are involved in the complaint process, as necessary;

2.10.9.8.7 A process for giving providers or their representatives the opportunity to present their cases in person;

2.10.9.8.8 Identification of specific individuals who have authority to administer the provider complaint process;

2.10.9.8.9 A system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation, whether received by telephone, in person, or in writing; and

2.10.9.8.10 A provision requiring the Contractor to report the status of all provider complaints and their resolution to LDH on a monthly basis in the format required by LDH.

2.10.9.9 The Contractor shall distribute, or make available in a readily accessible format, its policies and procedures to in-Network Providers at the time of execution of the Network Provider Agreement. The Contractor may distribute a summary of these policies and procedures to providers if the summary includes information about how the provider may access the full policies and procedures on the Contractor's website. This summary shall also detail how the Network Provider can request a hard copy from the Contractor at no charge to the provider.

2.10.9.10 The Contractor shall not prohibit, discourage, intimidate, or in any other way take retaliatory action against a provider that reports any complaint to LDH.

2.11 Provider Reimbursement

The Contractor shall administer an effective, accurate and efficient Claims processing system that Adjudicates provider Claims for MCO Covered Services that are filed within the timeframes specified in this Contract and in compliance with all applicable Federal and State laws, regulations, rules, policies, procedures, and manuals.

2.11.1 Minimum Reimbursement to In-Network Providers

2.11.1.1 The Contractor shall provide reimbursement for MCO Covered Services provided by an in-Network Provider.

2.11.1.2 For MCO Covered Services, the Contractor's rate of reimbursement shall be no less than the published FFS Rate in effect on the date of service or that is contained on the weekly procedure file sent to the Contractor by the FI, or its equivalent, unless mutually agreed to by both the Contractor and the provider in the Network Provider Agreement.

2.11.1.4 For non-emergency, non-ambulance medical transportation, the Contractor, or its Transportation Broker, and transportation provider may not mutually agree to a rate of reimbursement less than the FFS Rate. For inpatient hospital services, the Contractor shall have a system with the capacity to group Claims and reimburse under a Diagnosis Related Groups (DRG) methodology as defined by LDH within one hundred eighty (180) Calendar Days, or longer if deemed appropriate by LDH, of notification by LDH that such reimbursement methodology is required. Upon implementation of the methodology, the Contractor's rate of reimbursement shall be no less than the DRG rate established by LDH, unless mutually agreed to by both the Contractor and the provider in the Network Provider Agreement.

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2.11.1.5 For cost-based services, the Contractor's rate of reimbursement shall be no less than the published FFS Rate adjusted by the cost-based settlement.

2.11.1.6 For cases eligible for Outlier payments, the Contractor's rate of reimbursement shall be no less than the published FFS Rate plus the additional calculated outlier amount.

2.11.1.7 For providers with state Enrollment effective dates equal to or less than ninety (90) Calendar Days prior to execution of the Contractor's Network Provider Agreement, reimbursement shall be provided for dates of services on or after the state Enrollment effective date. For providers with state Enrollment effective dates greater than ninety (90) Calendar Days prior to execution of the Contractor's Network Provider Agreement, reimbursement shall be provided for dates of services on or after the Network Provider Agreement execution date. In either case, if a provider would otherwise be eligible for reimbursement at an earlier date under La. R.S. 46:460.62, then reimbursement shall be provided for dates of service on or after that date.

2.11.2 FQHC/RHC Contracting and Reimbursement

2.11.2.1 The Contractor shall ensure that its payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for services to Enrollees are greater than or equal to the payment amounts described in 42 U.S.C. §1396a(bb). In order to comply with this requirement, the Contractor shall pay FQHCs and RHCs at least the amount LDH would pay for such services through FFS as defined by the Prospective Payment System (PPS) rate or the Alternative Payment Methodology rate in effect on the date of service for each Encounter.

2.11.2.2 If the Contractor is unable to contract with an FQHC or RHC, the Contractor is not required to reimburse that FQHC or RHC without Prior Authorization for out-of-network services unless:

2.11.2.2.1 The medically necessary services are required to treat an Emergency Medical Condition; or

2.11.2.2.2 FQHC/RHC services are not available through at least one (1) MCO within LDH's established distance travel standards.

2.11.2.2.3 The Contractor may stipulate that reimbursement will be contingent upon receiving a Clean Claim and all the medical information required to update the Enrollee's medical record.

2.11.3 Indian Health Service (IHS) Providers

The Contractor shall reimburse the IHS provider at the annual rates published by the IHS in the Federal Register. IHS issues the payment rate based on a calendar year that will be

effective retroactive to January 1 of that year. The Contractor shall recycle Claims for the calendar year to capture the adjusted rate. See 42 CFR §438.14(c).

2.11.4 Reimbursement to Out-of-Network Providers

2.11.4.1 The Contractor shall make payment for covered emergency and post-stabilization services that are furnished to Enrollees by providers that have no contractual arrangements with the Contractor for the provision of such services. The Contractor shall reimburse the provider one hundred percent (100%) of the FFS Rate for Emergency Services. In compliance with Section 6085 of the Deficit Reduction Act (DRA) of 2005, reimbursement by the Contractor to out-of-Network Providers for the provision of Emergency Services shall be no more than the FFS Rate.

2.11.4.2 For services that do not meet the definition of Emergency Services, the Contractor shall compensate, at a minimum, ninety percent (90%) of the published FFS Rate in effect on the date of service to out-of-Network Providers to whom they have made at least three (3) documented attempts to include in their network (except as noted in this section for FQHCs, RHCs and IHS providers). The Contractor may require Prior Authorization for out-of-network services, unless services are required to treat an Emergency Medical Condition.

2.11.4.3 The Contractor shall not make payment for Community Psychiatric Support Treatment (CPST) or Psychosocial Rehabilitation (PSR) services that are furnished to Enrollees by providers that are out-of-network. The Contractor may make payment for CPST or PSR services only to those providers who are credentialed and participating in the provider network of the Contractor for the provision of such services, or who are licensed and accredited and have a single case agreement with the Contractor for provision of such services.

2.11.4.4 The Contractor shall reimburse out-of-Network Providers for the provision of services required by the *Continuity of Care* section at the in-network rate, in accordance with the *Minimum Reimbursement to In-Network Providers* section.

2.11.5 Effective Date of Payment for New Enrollees

The Contractor is responsible for payment of MCO Covered Services from an Enrollee's effective date of Enrollment with the Contractor.

2.11.6 Claims Processing Requirements

2.11.6.1 At a minimum, the Contractor shall run one (1) provider payment cycle per week, on the same day each week, as determined by the Contractor. For outpatient pharmacy claims, the Contractor shall run one (1) payment cycle per week, as determined by the Contractor. The Contractor shall

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support a CAQH/CORE compliant interface to the automated clearinghouse (ACH) that allows providers to request and receive electronic funds transfer (EFT) of Claims payments.

2.11.6.2 The Contractor shall encourage its providers to submit and receive Claims information through electronic data interchange (EDI) as an alternative to the filing of paper-based Claims.

2.11.6.3 Claims shall be processed in adherence to information exchange and data management requirements specified in this Contract.

2.11.6.4 The Contractor shall not pay any Claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid, or CHIP programs for Fraud, Waste, or Abuse or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employs someone on this list. The Contractor shall not pay any Claim submitted by a provider that is on payment suspension and/or withhold under the authority of LDH or its authorized agent(s).

2.11.6.5 The Contractor shall inform all Network Providers about Clean Claim requirements. The Contractor shall make requirements and guidelines for Claims coding and processing that are specific to Provider types available to Network Providers. The Contractor shall notify providers ninety (90) Calendar Days before implementing changes to Claims coding and processing guidelines, or as soon as possible if directed by LDH pursuant to Federal or State law, regulation, rule, or policy to implement such change earlier.

2.11.7 Inappropriate Payment Denials, Delays, or Recoupments

If the Contractor has a pattern, as determined by LDH, of inappropriately denying, delaying or recouping provider payments for services, the Contractor may be subject to suspension of new Enrollments, Monetary Penalties equal to one and one-half (1.5) times the value of the Claims inappropriately denied, delayed, or recouped, 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 instances from other sources).

2.11.7.1 If the Contractor has a pattern, as determined by LDH, of inappropriately denying, delaying, or recouping provider payments for services after the termination of the Contract, LDH may impose Monetary Penalties equal to one and one-half (1.5) times the value of the Claims inappropriately denied, delayed, or recouped. LDH may, at its sole discretion, make a claim against the performance bond or deduct from the withhold of the final payment to satisfy the Monetary Penalties imposed.

2.11.8 Payment for Emergency Services and Post-Stabilization Services

2.11.8.1 The Contractor shall reimburse providers for Emergency Services rendered without a requirement for Service Authorization of any kind.

2.11.8.2 The Contractor's protocol for provision of Emergency Services shall specify that Emergency Services shall be covered when furnished by a provider with whom the Contractor does not have a Network Provider Agreement or referral arrangement.

2.11.8.3 The Contractor may not limit what constitutes an Emergency Medical Condition on the basis of diagnoses or symptoms.

2.11.8.4 The Contractor shall not deny payment for treatment obtained under either of the following circumstances:

2.11.8.4.1 An Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or

2.11.8.4.2 A representative of the Contractor instructs the Enrollee to seek Emergency Services.

2.11.8.5 The Contractor shall not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent's failure to notify the Enrollee's PCP or the Contractor of the Enrollee's screening and treatment within ten (10) Calendar Days of presentation for Emergency Services.

2.11.8.6 The Contractor shall be financially responsible for Emergency Services, including transportation, and shall not retroactively deny a Claim for Emergency Services, including transportation, to an emergency provider because the condition, which appeared to be an Emergency Medical Condition under the prudent layperson standard, was subsequently determined to be non-emergent in nature.

2.11.8.7 The Contractor is financially responsible for post-stabilization care services, as specified in 42 CFR §438.114(e) and §422.113(c), obtained within or outside the network that are:

2.11.8.7.1 Pre-approved by a Network Provider or other Contractor representative; or

2.11.8.7.2 Not pre-approved by a Network Provider or other Contractor representative, but:

2.11.8.7.2.1 Administered to maintain the Enrollee's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further post-stabilization care services;

2.11.8.7.2.2 Administered to maintain, improve or resolve the Enrollee's stabilized condition if the Contractor:

Does not respond to a request for pre-approval within one (1) hour;

Cannot be contacted; or

Contractor's representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a network physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of 42 CFR §422.113(c)(3) is met.

2.11.8.7.2.3 Are for post-stabilization hospital-to-hospital ambulance transportation of Enrollees with a behavioral health condition, including hospital to behavioral health specialty hospital.

2.11.8.8 The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor as responsible for coverage and payment as per 42 CFR §438.114(d). The Contractor's financial responsibility ends for post stabilization care services it has not pre-approved when:

2.11.8.8.1 A network physician with privileges at the treating hospital assumes responsibility for the Enrollee's care;

2.11.8.8.2 A network physician assumes responsibility for the Enrollee's care through transfer;

2.11.8.8.3 A representative of the Contractor and the treating physician reach an agreement concerning the Enrollee's care; or

2.11.8.8.4 The Enrollee is discharged.

2.11.9 Non-Payment for Specified Services

The Contractor shall deny payment to providers for deliveries occurring before thirty-nine (39) weeks without a medical indication.

2.11.10 Provider Preventable Conditions (PPCs)

2.11.10.1 The Contractor shall deny payment to providers for PPCs that meet the following criteria:

2.11.10.1.1 Is identified in the State Plan;

2.11.10.1.2 Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

2.11.10.1.3 Has a negative consequence for the Beneficiary;

2.11.10.1.4 Is auditable; and

2.11.10.1.5 Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.

2.11.10.2 The Contractor shall require all providers to report PPCs associated with Claims for payment or Enrollee treatments for which payment would otherwise be made. PPCs should be identified on the Encounter file via the Present on Admission (POA) indicators.

2.11.11 Payment for Pharmacy Services

The Contractor and the Contractor's PBM are prohibited from reimbursing pharmacies that are owned by the Contractor and/or the PBM at a rate higher than pharmacies that are not owned by the Contractor and/or the PBM.

2.11.12 Payment for Newborn Care

The Contractor shall cover all newborn care rendered within the first month of life regardless of whether provided by the designated PCP or another Network Provider. The Contractor shall compensate, at a minimum, ninety percent (90%) of the FFS Rate in effect for each service coded as a primary care service rendered to a newborn within thirty (30) Calendar Days of the Enrollee's birth regardless of whether the provider is part of the Contractor's network, but subject to the same requirements as a Network Provider.

2.11.13 Payment for Hospital Services

The Contractor is not responsible for reimbursement of graduate medical education (GME) payments or disproportionate share hospital (DSH) payments to providers.

In accordance with 42 CFR §438.6(c), the Department will utilize a CMS approved directed payment arrangement for specified hospitals. The payment arrangement will utilize a uniform percentage increase for qualified hospitals, based upon assigned tiered provider classes, for inpatient and outpatient MCO Covered Services provided to Enrollees. CMS approval of a directed payment arrangement is for one (1) rating period and it is not renewed automatically. As such, this directed payment arrangement must be approved by CMS annually.

This directed payment arrangement will be made through a separate payment term outside of the monthly Capitation Payment.

The Contractor shall make directed payments to qualified hospitals as directed by the Department and in accordance with the written approval from CMS for the applicable rating period.

2.11.13.1 For each State Fiscal Year (SFY), pursuant to CMS approvals, LDH will provide a uniform percentage increase for in-state providers of inpatient and outpatient hospital services (excluding freestanding psychiatric

hospitals, freestanding rehabilitation hospitals, and long-term acute care hospitals) and a separate uniform percentage increase for long-term acute care, psychiatric services, and rehabilitation services for both inpatient and outpatient hospital services for the rating period covering that SFY. This directed payment arrangement shall be detailed in Attachment D, *Actuarial Rate Certification Letter*.

LDH shall utilize an interim payment process, whereby interim directed payments will be calculated based upon the utilization data for the period specified in the approved CMS preprint and paid to qualified hospitals on a quarterly basis. LDH shall provide a quarterly interim direct payment report to the Contractor for each quarter, which identifies the qualified hospitals and the applicable interim directed payment for that quarter. The Contractor shall pay the interim directed payments to the appropriate qualified hospitals, as specified in that report, within ten (10) Business Days of receipt of the report from LDH, unless otherwise directed in writing by the Hospital and Facility Finance Director or the LDH Undersecretary. The Contractor shall not deviate from the payments set forth in the quarterly interim direct payment report, unless otherwise directed in writing by the Hospital and Facility Finance Director or the LDH Undersecretary. If the Contractor fails to pay an interim directed payment in full or within the specified time period for a given quarter, LDH may penalize the Contractor using one (1) or more of the following:

- One (1) or more remedies in the *Contract Non-Compliance section*, including, but not limited to, Contract termination;
- Attachment G, *Table of Monetary Penalties*; and
- A partial or complete forfeiture of any interest earned on the directed payments provided to the Contractor.

In accordance with Federal regulations, directed payments must be based on actual utilization and delivery of services. As such, within twelve (12) months of the end of the SFY, LDH will perform a reconciliation and provide the Contractor with a reconciliation report that will contain the adjustments to be made to each qualified hospital's next quarterly interim directed payment. If the Contractor fails to perform the reconciliation in accordance with the instructions or within the specified time period, LDH may penalize the Contractor using one (1) or more of the following:

- One (1) or more remedies in the *Contract Non-Compliance* section, including, but not limited to, Contract termination;
- Attachment G, *Table of Monetary Penalties*; and
- A partial or complete forfeiture of any interest earned on the net directed payments provided to the Contractor.

Annually, unless otherwise directed by LDH, the Contractor shall stratify and report on select performance measure results in Attachment H, Quality Performance Measures, using a template provided by LDH.

2.11.14 Payment for Recruitment and Retention Incentives for psychiatrists and Licensed Mental Health Professionals

In accordance with 42 CFR §438.6(c), LDH will utilize ~~a~~ CMS-approved directed payment arrangements for specified Network Providers. The payment arrangements will utilize a series of uniform incentive payments dependent upon the retention or recruitment category within which the eligible Network Provider falls. CMS approval of a directed payment arrangement is for one (1) rating period and it is not renewed automatically.

These directed payment arrangements will be made through a separate payment term outside of the monthly Capitation Payment. Separate payment term(s) will be captured in the applicable rate certifications(s) but paid separately to the Contractor from the monthly base capitation rates paid to the Contractor based on the American Rescue Plan Act, 9817 funding.

The Contractor shall make directed payments to qualified Network Providers as directed by LDH and in accordance with the written approval from CMS for the applicable rating period.

2.11.14.1 For SFY 2024, LDH will provide incentive payments for psychiatrists and LMHPs who are enrolled with the Contractor, and have provided at least one (1) eligible home or community based specialized behavioral health service during the rating period of SFY 2023.

2.11.14.2 For SFY 2024, LDH will provide incentive payments for psychiatrists and LMHPs who are enrolled with the Contractor and have been certified in one (1) or more of the following EBPs on or after January 1, 2021:

- 0-5 Parent Psychotherapy
- Trauma-Focused Cognitive Behavioral Therapy
- Parent-Child Interaction Therapy
- Preschool Post-Traumatic Stress Disorder Treatment
- Youth Post-Traumatic Stress Disorder Treatment
- Positive Parenting Program
- Eye Movement Desensitization and Reprocessing for Adolescents

2.11.14.2.1 Network Providers are only eligible for one (1) incentive payment per EBP service type for which they qualify.

2.11.14.3 For SFY 2024, LDH will provide retention payments for psychiatrists and LMHPs who have been enrolled with the Contractor for a minimum of six (6) consecutive months, certified in one (1) or more of the EBPs identified in this section, and who have provided at least one (1) eligible home or community based EBP service for which they are certified, during SFY 2024.

2.11.14.4 For applicable dates of service within SFY 2024, unless a renewal is approved by CMS, and enacted by LDH, a State-directed payment arrangement will be utilized for a temporary, uniform rate increase for certain individual or group psychotherapy services over the Medicaid FFS fee schedule in effect as of July 1, 2023 for services provided by an enrolled qualified provider that utilizes Dialectical Behavior Therapy (DBT), an individual or group psychotherapy Evidence-Based Practice. The Contractor shall ensure compliance with the applicable CMS-approved State-directed payment preprint for DBT services.

2.11.14.4.1 Eligible providers will be paid by the Contractor based on submission of eligible claims. The Contractor must ensure the accurate and timely processing of Claims and Encounters. The Contractor will be eligible to receive reimbursement from LDH for the DBT add-on portion of the total reimbursement paid for the applicable individual or group psychotherapy services. To receive reimbursement, the Contractor will invoice LDH on a quarterly basis for the portion of the claims attributable to the state directed payment. The initial invoice is due by the fifteenth (15th) of the month following the close of the first eligible calendar year quarter during which a Contractor will be reimbursed by LDH within thirty (30) Calendar Days of invoice receipt.

2.11.14.5 This directed payment arrangement shall be detailed in Attachment D, *Actuarial Rate Certification Letter*.

2.11.15 Payment for Physician Services

The Contractor shall use the increased physician services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Pricing, or any successive payment model, as detailed in Attachment D, *Actuarial Rate Certification Letter*, for reimbursement of physician services in compliance with 42 CFR §438.6.

2.11.16 Payment for Incentives for NEMT Providers

In accordance with 42 CFR §438.6(c), LDH will utilize a CMS-approved directed payment arrangement for specified NEMT Providers. The payment arrangement will utilize a series of uniform incentive payments dependent upon the Provider meeting monthly thresholds of provided trips. CMS approval of a directed payment arrangement is for one (1) rating period and it is not renewed automatically.

This directed payment arrangement will be made through a separate payment term outside of the monthly Capitation Payment.

The Contractor shall make directed payments to eligible NEMT Providers as directed by LDH and in accordance with the written approval from CMS for the applicable rating period.

2.11.16.1 For each State Fiscal Year (SFY), pursuant to CMS approval, LDH will provide incentive payments for NEMT Providers who have delivered at least one non-emergency medical round trip, consisting of a minimum of two (2) legs, per calendar day for an Enrollee for a minimum of twenty (20) Calendar Days per previous calendar month and is fully credentialed in the Louisiana Medicaid Program during the reporting period.

2.11.16.2 NEMT Providers are only eligible for one (1) incentive payment per vehicle, up to a maximum of three (3) vehicles, per month for which they qualify.

2.11.16.3 This directed payment arrangement shall be detailed in Attachment D, Actuarial Rate Certification Letter.

2.11.17 Federal Responsibility for Payment for SBHS Provided to Enrollees Participating in Coordinated System of Care

2.11.17.1 The CSoC contractor shall be responsible for payment to enrolled providers for the provision of SBHS, with the exception of PRTF, TGH, and SUD Residential treatment services, for each month during which the Enrollee has a 1915(c)/1915(b)(3) Waiver segment on the eligibility file with a begin date on or earlier than the first (1st) Calendar Day of that month, or in the event that an Enrollee transfers between Waivers during the month, but the previous segment began on or earlier than the first (1st) Calendar Day of that month.

2.11.17.2 The CSoC contractor shall be responsible for payment to enrolled providers for the provision of SBHS through the last Calendar Day of the month which includes the end date of the 1915(c)/1915(b)(3) segment on the eligibility file.

2.11.17.3 The Contractor shall be responsible for payment to enrolled providers for the provision of SBHS for any month during which the Enrollee has a 1915(c)/1915(b)(3) segment on the eligibility file with a begin date later than the first (1st) Calendar Day of that month.

2.11.17.4 The Contractor shall be responsible for payment of all PRTF, TGH, and SUD Residential treatment services for CSoC enrolled youth.

2.11.17.5 If an Enrollee no longer meets medical necessity criteria for a higher level of care (i.e., inpatient hospital) that was authorized by the CSoC

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contractor, and the Contractor has authorized PRTF, TGH, or SUD Residential treatment services, but is unable to secure placement, the Contractor shall be responsible for assuming the continued authorization of, and payment for, the higher level service until placement is made, regardless of the Enrollee's CSoC Enrollment status, unless the Child and Family Team (CFT) agrees that the Enrollee's behavioral health and/or medical condition is stable enough for the Enrollee to be safely discharged home, and the CFT has made a plan to support the Enrollee and family with outpatient care until placement in residential treatment is secured.

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2.11.18 Payment for Recruitment and Retention Incentives for Nurses Providing Skilled Nursing Services in the Extended Home Health Program

In accordance with 42 CFR §438.6(c), LDH will utilize a directed payment arrangement to disburse recruitment and retention bonuses for skilled nursing services provided under the extended home health program. The payment arrangement will be dependent upon the nurse meeting monthly service thresholds. CMS approval of a directed payment arrangement is for one (1) rating period and it is not renewed automatically.

This directed payment arrangement will be made through a separate payment term outside of the monthly Capitation Payment.

The Contractor shall make directed payments to qualified Network Providers as directed by LDH and in accordance with the written approval from CMS for the applicable rating period.

2.11.18.1 LDH will provide a one-time recruitment lump sum payment contingent upon the nurse meeting service thresholds. Individual nurses are only eligible to receive to the recruitment lump sum bonus once.

2.11.18.2 For each State Fiscal Year (SFY), pursuant to CMS approval, LDH will provide an additional recurring monthly retention payment to qualified thresholds. Additionally, the home health agency employing the nurse(s) will be eligible to receive a monthly administrative fee.

2.11.18.3 This directed payment arrangement shall be detailed in Attachment D, *Actuarial Rate Certification Letter*.

2.12 Utilization Management

The Contractor shall develop a utilization management (UM) program for all MCO Covered Services that facilitates the delivery of high quality, cost-efficient, and effective care.

2.12.1 General Requirements

2.12.1.1 The Contractor shall develop and maintain written program policies and procedures with defined structures and processes that meet NCQA standards.

2.12.1.2 The Contractor shall submit written policies and procedures to LDH or its designee for approval as part of Readiness Review and prior to any

substantive changes. Policies and procedures shall include, but not be limited to:

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

2.12.1.2.1.1.1 For SBHS, as defined in Attachment B, MCO Covered Services, the Contractor shall provide the following for each unique service;Any Prior Authorization requirements;

2.12.1.2.1.1.2 Number of pass-through visits or Encounters permitted as applicable;

2.12.1.2.1.1.3 Detailed medical necessity criteria and source, and clinical documentation required for prior authorization and decision-making;

2.12.1.2.1.1.4 Comprehensive Service Authorization criteria and source used by the Contractor's staff to determine whether a service should be approved or partially denied; and

2.12.1.2.1.1.5 Standard authorization period indicating how long a service is typically authorized by the MCO.

2.12.1.2.2 Provisions for ensuring confidentiality of clinical information;

2.12.1.2.3 The reporting of Fraud and Abuse information identified through the program to LDH in accordance with 42 CFR §455.1(a)(1);

2.12.1.2.4 Policies and procedures to maintain, or require providers and contractors to maintain, an individual health record for each Enrollee, in accordance with the **MCO Manual**. The Contractor shall collect and provide health records to LDH upon request; and

2.12.1.2.5 Where applicable, the requirement that each Enrollee's record includes information needed to perform utilization reviews. This information must include, at least, the following:

2.12.1.2.5.1 Identification of the Enrollee;

2.12.1.2.5.2 The name of the Enrollee's physician;

2.12.1.2.5.3 Date of admission, and dates of application for and authorization of Louisiana Medicaid Program benefits if application is made after admission;

2.12.1.2.5.4 The POC required under 42 CFR §456.80 and §456.180;

2.12.1.2.5.5 Initial and subsequent continued stay review dates described under 42 CFR §456.128, §456.133, §456.233, and §456.234;

2.12.1.2.5.6 Date of operating room reservation, if applicable; and

2.12.1.2.5.7 Justification of emergency admission, if applicable.

2.12.1.3 All documentation and/or records maintained by the Contractor, its Material Subcontractors, and its Network Providers related to MCO Covered Services, charges, operations and agreements under this Contract shall be maintained for at least ten (10) calendar years following termination of the Contract unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the State or Federal government. Under no circumstances shall the Contractor or any of its Material Subcontractors destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

2.12.1.4 The Contractor shall submit utilization management reports as specified by LDH.

2.12.2 Utilization Management Committee

2.12.2.1 The UM program shall include a UM Committee that integrates with other functional units of the Contractor as appropriate and supports the Quality Assessment and Performance Improvement (QAPI) Program in accordance with the *Quality Management and Quality Improvement* section.

2.12.2.2 UM Committee responsibilities include:

Deleted: The UM Committee shall provide utilization review and monitoring of UM activities of both the Contractor and its providers and is directed by the Contractor's Medical Director. The UM Committee shall convene no less than quarterly and shall make meeting minutes available to LDH upon request. LDH representatives, as appointed by LDH, shall be included as members of the UM Committee, if requested.

2.12.2.2.1 Reviewing, updating, and approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;

2.12.2.2.2 Monitoring the medical appropriateness and necessity of health care services provided to its Enrollees;

2.12.2.2.3 Monitoring providers' requests for Prior Authorization of health care services to its Enrollees;

2.12.2.2.4 Monitoring consistent application of Service Authorization criteria;

2.12.2.2.5 Monitoring over- and under-utilization;

2.12.2.2.6 Review of Outliers; and

2.12.2.2.7 Monitoring of health record reviews.

2.12.3 General Service Authorization Requirements

2.12.3.1 The Contractor shall have clearly delineated Service Authorization procedures for Prior Authorization, concurrent authorization, and post authorization that comply with 42 CFR §438.210 and any court-ordered requirements of LDH. For pharmacy Service Authorizations, see the **MCO Manual**.

2.12.3.2 The Contractor may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the Enrollee.

2.12.3.3 The Contractor must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

2.12.3.4 The Contractor shall not be required to pay for a particular item or service when the provider does not provide requested medical information for purposes of making a Service Authorization determination, for that particular item or service.

2.12.3.5 All court-ordered behavioral health services are subject to medical necessity review. In order for the service to be eligible for reimbursement, the Contractor shall determine that the service is medically necessary and an MCO Covered Service.

2.12.3.6 The Contractor shall develop and implement written procedures including, but not limited to, the following:

2.12.3.6.1 A process for submission and processing of requests for initial and continuing authorizations of services;

2.12.3.6.1.1 The Contractor is responsible for eliciting pertinent health record information from the treating health care provider(s), as needed and/or as requested by LDH, for purposes of making Service Authorization determinations.

2.12.3.6.1.2 The Contractor shall take appropriate action when a treating health care provider does not provide complete medical history information within the requested timeframe.

2.12.3.6.2 The process to be followed in the event the Contractor determines the need for additional information not initially requested;

2.12.3.6.3 The process for conducting peer-to-peer reviews of adverse determinations;

2.12.3.6.4 A process to ensure that authorization requirements of the Contractor shall either be furnished to the healthcare provider within twenty-four (24) hours of a request for the requirement. In

addition, the Contractor shall post a list of all items and services that require prior authorization in an easily searchable format, that includes the date of last review, on the Contractor's public website. The Contractor shall furnish these requirements to Providers in addition to the Prior Authorization information and training that must be furnished under the *Provider Services and Support* section;

2.12.3.6.5 A process to arrange for another level of care if appropriate when the Contractor denies a Service Authorization request. For SBHS, the Contractor shall have a process by which the Contractor's staff may connect the Enrollee to another service or service provider (e.g., locating a provider, confirming the provider has availability, and/or securing an appointment), if appropriate, to ensure Enrollee continuity of care; and

2.12.3.6.6 A mechanism by which an Enrollee may submit, verbally or in writing, a Service Authorization request. This process shall also be included in the Member Handbook and incorporated in the Grievance procedures.

2.12.4 Service Authorization Criteria

2.12.4.1 The Contractor shall ensure that Service Authorization criteria are consistent with applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, and Waivers;

2.12.4.2 The Contractor shall use LDH's definition of medically necessary services;

2.12.4.3 The Contractor shall only use criteria that:

2.12.4.3.1 Are adopted in consultation with contracted healthcare providers;

2.12.4.3.2 Are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

2.12.4.3.3 Consider the needs of the Enrollees; and

2.12.4.3.4 Are updated periodically as appropriate.

2.12.4.4 The Contractor shall clearly identify the source of the criteria and include:

2.12.4.4.1 The vendor if the criteria were purchased;

2.12.4.4.2 The association if the criteria are developed/recommended or endorsed by a national or state health care provider association or society; and/or

2.12.4.4.3 The guideline source if the criteria are based on a published clinical practice guideline.

2.12.4.5 The Contractor shall establish and implement a six (6) month Service Authorization period for CPST and PSR services unless otherwise approved by LDH based on justification provided by the Contractor.

2.12.5 Service Authorization Staffing Requirements

2.12.5.1 The Contractor shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary MCO Covered Services to any Enrollee in accordance with 42 CFR §438.3(i) and 42 CFR §422.208.

2.12.5.1.1 The Contractor shall make eighty percent (80%) of standard Service Authorization determinations within two (2) Business Days of obtaining appropriate documentation that may be required regarding a proposed procedure, or service requiring a review determination, with the following exceptions:

2.12.5.1.1.1 The Contractor shall make all of inpatient hospital Service Authorizations within two (2) Calendar Days of obtaining appropriate documentation.

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2.12.5.3 The Contractor shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of an Enrollee's condition or disease and training in the use of any required assessments shall determine Service Authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

2.12.5.3.1 The individual making determinations shall attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of the individual's expertise.

2.12.5.4 The Contractor shall ensure that staff consistently and correctly apply authorization criteria and make appropriate determinations, including a process to ensure staff performing below acceptable thresholds on inter-rater reliability tests are not permitted to make independent authorization determinations until such time that the staff member can be retrained, monitored, and demonstrate performance that meets or exceeds the acceptable threshold;

2.12.5.5 The individual(s) making determinations shall have no history of disciplinary action or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.

2.12.5.6 The Contractor shall provide staff specifically assigned to:

2.12.5.6.1 SBHS; and

2.12.5.6.2 PSH to ensure appropriate authorization of tenancy services.

2.12.5.6 The Contractor shall ensure that all staff making Service Authorization decisions for SBHS participate in training and inter-rater reliability testing at least annually, or more frequently based on updates to the service definition or medical necessity criteria.

2.12.6 Service Authorization Determination Timing and Notices

2.12.6.1 Standard Service Authorization

2.12.6.1.1 The Contractor shall make eighty percent (80%) of standard Service Authorization determinations within two (2) Business Days of obtaining appropriate documentation that may be required regarding a proposed procedure, or service requiring a review determination, with the following exceptions:

2.12.6.1.1.1 The Contractor shall make all inpatient hospital Service Authorizations within two (2) Calendar Days of obtaining appropriate documentation; and

2.12.6.1.1.2 The Contractor shall make all CPST and PSR Service Authorizations within five (5) Calendar Days of obtaining appropriate documentation.

2.12.6.1.1.3 The MCO shall make all determinations for any behavioral health crisis services that require Prior Authorization as expeditiously as the Enrollee's condition requires, but no later than one (1) Calendar Day after obtaining appropriate clinical documentation.

2.12.6.1.2 All standard Service Authorization determinations shall be made no later than seven (7) Calendar Days following receipt of the request for service.

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2.12.6.1.3 The Service Authorization determination may be extended up to an additional fourteen (14) additional Calendar Days if:

2.12.6.1.3.1 The Enrollee, or the provider, requests the extension; or

2.12.6.1.3.2 The Contractor justifies (to LDH upon request) a need for additional information and how the extension is in the Enrollee's interest.

2.12.6.1.4 The Contractor shall make all concurrent review determinations within one (1) Calendar Day of obtaining the appropriate medical information that may be required.

2.12.6.2 Expedited Service Authorization

2.12.6.2.1 In the event a provider indicates, or the Contractor determines, that following the standard Service Authorization timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization determination and provide notice as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.

2.12.6.3 **2.12.6.2.2** The Contractor may extend the seventy-two (72) hour time period by up to fourteen (14) Calendar Days if the Enrollee requests the extension or if the Contractor justifies to LDH a need for additional

information and how the extension is in the Enrollee's best interest.Post Authorization

2.12.6.3.1 The Contractor shall make retrospective review determinations within thirty (30) Calendar Days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred eighty (180) Calendar Days from the date of receipt of request for Service Authorization.

2.12.6.3.2 The Contractor shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous Service Authorization approval, unless the approval was based upon a material omission or misrepresentation about the Enrollee's health condition made by the provider.

2.12.6.3.3 The Contractor shall not use a policy with an effective date subsequent to the original Service Authorization request date to rescind its Prior Authorization.

2.12.6.4 Notices of Determinations

2.12.6.4.1 Service Authorization Approvals

2.12.6.4.1.1 For Service Authorization approval for a non-emergency admission, procedure or service, the Contractor shall notify the provider as expeditiously as the Enrollee's health condition requires but not more than one (1) Business Day of making the initial determination and provide written notification to the provider within two (2) Business Days of making the determination.

2.12.6.4.1.2 For Service Authorization approval for extended stay or additional services, the Contractor shall notify the provider rendering the service, whether a health care professional or facility or both, and the Enrollee receiving the service, verbally or as expeditiously as the Enrollee's health condition requires but not more than one (1) Business Day of making the initial determination and shall provide written notification to the provider within two (2) Business Days of making the determination.

2.12.6.4.2 Adverse Action

2.12.6.4.2.1 The Contractor shall notify the Enrollee, in writing using language that is easily understood by the Enrollee, of determinations to deny a Service Authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in the *Enrollee Grievances, Appeals and State Fair Hearings* section. The notice of action to Enrollees shall be consistent with requirements in 42 CFR §438.404, §438.10, and §438.210, the *Marketing and Education* section for Enrollee written materials, and any agreements that the Department may have entered into relative to the contents of Enrollee notices of denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out-of-court settlements.

2.12.6.4.2.2 The Contractor shall notify the requesting provider of a determination to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested and include the denial reason.

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The Contractor shall provide written notification to the provider rendering the service, whether a health care professional or facility or both, within two (2) Business Days of making the determination.

2.12.6.4.3 Informal Reconsideration

2.12.6.4.3.1 As part of the Contractor's Appeal Procedures, the Contractor shall include an Informal Reconsideration process that allows the Enrollee (or provider/agent on behalf of an Enrollee) a reasonable opportunity to present evidence, and allegations of fact or law, in person and in writing.

2.12.6.4.3.2 In a case involving an initial determination or a concurrent review determination, the Contractor shall provide the Enrollee or a provider acting on behalf of the Enrollee and with the Enrollee's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [42 CFR §438.402(c)(1)(ii)]. For SBHS, the Contractor shall clearly identify the documentation to be submitted by the provider to obtain approval of SBHS or a more appropriate course of action or treatment based upon the approved Service Authorization criteria.

2.12.6.4.3.3 The Contractor shall offer the informal reconsideration at a mutually agreed upon time, which shall occur within one (1) Business Day of the receipt of the request and shall be conducted between the provider rendering or recommending the service and the Contractor's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) Business Day.

2.12.6.4.3.4 The Informal Reconsideration does not extend the thirty (30) Calendar Day required timeframe for a Notice of Appeal Resolution.

2.12.7 Service Authorization Requirements for New Enrollees

2.12.7.1 General Requirements

2.12.7.1.1 The Contractor shall not require Service Authorization for the continuation of medically necessary MCO Covered Services of a new Enrollee transitioning into the Contractor, regardless of whether such services are provided by an in-network or out-of-Network Provider, however, the Contractor may require Prior Authorization of services beyond thirty (30) Calendar Days.

2.12.7.1.2 For the first thirty (30) Calendar Days of Enrollment, the Contractor is prohibited from denying Prior Authorization solely on the basis of the provider being an out-of-Network Provider.

2.12.7.2 Pregnancy

2.12.7.2.1 In the event a new Enrollee is in the first trimester of pregnancy and is actively receiving medically necessary covered prenatal care services at the time of Enrollment, the Contractor shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of authorization

needed and without regard to whether such services are being provided by a network or non-Network Provider until such time as the Contractor can reasonably transfer the Enrollee to a Network Provider without impeding service delivery that might be harmful to the Enrollee's health.

2.12.7.2.2 In the event a new Enrollee is in her second or third trimester of pregnancy and is actively receiving medically necessary covered prenatal care services at the time of Enrollment, the Contractor shall be responsible for providing continued access to the prenatal care provider (whether network or non-Network Provider) for sixty (60) Calendar Days postpartum, provided the Enrollee remains covered through Contractor, or referral to a safety net provider if the Enrollee's eligibility terminates before the end of the postpartum period.

2.12.7.2.3 In the event a new Enrollee is actively receiving medically necessary MCO Covered Services other than prenatal services at the time of Enrollment, the Contractor shall be responsible for the costs of continuation of such medically necessary services, without any form of authorization needed and without regard to whether such services are being provided by network or non-Network Providers. The Contractor shall provide continuation of such services up to ninety (90) Calendar Days or until the Enrollee may be reasonably transferred to an in-Network Provider without disruption, whichever is less. The Contractor may require Prior Authorization for continuation of the services beyond thirty (30) Calendar Days; however, the Contractor is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.

2.12.7.2.4 The Contractor shall ensure that the Enrollee is held harmless by the provider for the costs of the above medically necessary MCO Covered Services.

2.12.7.3 Special Health Care Needs

2.12.7.3.1 Where a new Enrollee with SHCN is actively receiving medically necessary MCO Covered Services at the time of Enrollment, the Contractor shall provide continuation/coordination of such services up to ninety (90) Calendar Days or until the Enrollee may be reasonably transferred to a Network Provider without disruption, whichever is less. The Contractor may require Prior Authorization for continuation of the services beyond thirty (30) Calendar Days; however, the Contractor is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.

2.12.7.4 Maintenance Medications

2.12.7.4.1 The Contractor shall submit for approval, a transition of care program that ensures Enrollees can continue treatment of maintenance medications for at least sixty (60) Calendar Days after Enrollment with the Contractor or switching from one plan to another. The Contractor shall continue any treatment of antidepressants and antipsychotics for at least sixty (60) Calendar Days after Enrollment with the Contractor. Additionally, an Enrollee that is, at the time of Enrollment with the Contractor, receiving a prescription drug that is not on the PDL shall be permitted to continue to receive that prescription drug if medically necessary for at least sixty (60) Calendar Days.

2.12.7.5 DME, Prosthetics, Orthotics, and Certain Supplies

2.12.7.5.1 In the event an Enrollee who is newly enrolled with the Contractor is actively receiving Medicaid covered durable medical equipment, prosthetics, orthotics, and certain supplies services at the time of Enrollment, whether such services were provided by another MCO or FFS, the Contractor shall be responsible for the costs of continuation of these services, without any form of authorization and without regard to whether such services are being provided by network or non-Network Providers. The Contractor shall provide continuation of such services for up to ninety (90) Calendar Days or until the Enrollee may be reasonably transferred to a Network Provider (within the timeframe specified in this Contract) without disruption, whichever is less.

2.12.7.5.2 The Contractor shall also honor any Prior Authorization for durable medical equipment, prosthetics, orthotics and certain supplies services issued while the Enrollee was enrolled in another MCO or FFS for a period of ninety (90) Calendar Days after the Enrollee's Enrollment.

2.12.8 Other Service Authorization Requirements

2.12.8.1 The Medicaid Executive Director, in consultation with the Medicaid Medical Director, may require the Contractor to authorize services on a case-by-case basis.

2.12.8.2 The Contractor shall not deny continuation of higher-level services (e.g., inpatient hospital or PRTF) for failure to meet medical necessity unless the Contractor can provide the service through an in-network or out-of-Network Provider at a lower level of care.

2.12.8.3 The Contractor shall utilize a common hospital observation policy that is developed and maintained collectively by the MCOs with approval by LDH in writing. Any revisions shall be reviewed and approved by LDH in writing at least thirty (30) Calendar Days prior to implementation.

2.12.8.4 The Contractor shall perform Prior Authorization and concurrent utilization review for admissions to inpatient general hospitals and concurrent utilization review for psychiatric admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals.

2.12.8.5 The Contractor shall ensure that initial and concurrent inpatient psychiatric hospital utilization reviews are completed by a Licensed Mental Health Professional (LMHP), psychiatrist, or registered nurse with the appropriate clinical expertise for each Enrollee.

2.12.8.6 The Contractor should coordinate the development of Service Authorization policies with other MCOs where appropriate to avoid providers receiving conflicting policies from different MCOs.

2.12.8.7 The Contractor shall not require Service Authorization for:

2.12.8.7.1 Emergency Services or post-stabilization services as described in this Section whether provided by an in-network or out-of-Network Provider;

2.12.8.7.2 Non-emergency inpatient hospital admissions for normal newborn deliveries; and

2.12.8.7.3 EPSDT screening services.

2.12.9 Gold Card Program for Providers

2.12.9.1 The Contractor shall establish and implement a Gold Card Program designed to recognize and incentivize high-performing providers who demonstrate consistent quality of care, compliance with clinical guidelines, and efficiency in service delivery.

2.12.9.2 Provider Eligibility. The Contractor shall develop and maintain written criteria for designation as a Gold Card Provider. Such criteria may include, but are not limited to:

2.12.9.2.1 Demonstrated adherence to evidence-based clinical protocols;

2.12.9.2.2 Favorable utilization review outcomes;

2.12.9.2.3 Timely and accurate submission of claims; and

2.12.9.2.4 Positive performance on applicable quality and outcome measures.

2.12.9.3 Program Benefits. The Contractor may extend streamlined administrative processes to Gold Card Providers, which may include, but are not limited to reduced or waived prior authorization requirements;

2.12.9.4 Duration and Review. Gold Card designation shall remain in effect for a period determined by the Contractor, subject to periodic review and renewal based on continued provider performance. The Contractor reserves the right to revoke or suspend Gold Card status if a provider no longer meets eligibility requirements or engages in conduct inconsistent with Program objectives.

2.12.9.5 Notice to Providers. The Contractor shall provide written notice to providers of their eligibility, designation, or removal from the Gold Card Program, including the basis for such determination.

2.12.9.6 A Gold Card Program proposal must be submited to LDH for approval by March 1, 2026 for an effective date of July 1, 2026.

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2.12.10 Health Record Review

2.12.10.1 By sampling or other methods and on a regular basis, the Contractor shall verify that services for which reimbursement was made were provided to Enrollees as billed.

2.12.10.2 The standards, which shall include all health record documentation requirements addressed in the Contract, shall be distributed to all providers.

2.12.10.3 The Contractor shall conduct reviews at all PCP sites with fifty (50) or more linked Enrollees and practice sites which include both individual offices and large group facilities. The Contractor shall review each site at least one (1) time during each two (2) year period.

2.12.10.3.1 The Contractor shall review a reasonable number of records at each site to determine compliance. Five (5) to ten (10) records per site is a generally accepted target. For large group practices (six [6] or more providers in the group), three (3) record reviews per provider shall be required.

2.12.10.4 The Contractor shall report the results of health record reviews to LDH quarterly with an annual summary.

2.12.11 CSoC Requirements

2.12.11.1 The Contractor shall conduct UM functions for the CSoC population. The Contractor shall:

2.12.11.1.1 Apply initial risk screen for CSoC eligibility;

2.12.11.1.2 Refer calls (via a seamless "warm transfer") to the contracted administrator of the CSoC program, who shall apply Brief CANS assessment tool to assess for CSoC presumptive eligibility; and

2.12.11.1.3 Document in the child's health record whether or not (according to CSoC contracted administrator) the child met criteria for CSoC presumed eligibility, when the child was referred to the WAA, and the date on which the Freedom of Choice (FOC) was signed.

2.12.11.2 The Contractor shall also document in the child's health record if the child does not become enrolled in CSoC, for the reasons of 1) the youth and family refuse CSoC services, or 2) the youth does not meet clinical eligibility based on the comprehensive CANS, or 3) for any other reason.

2.12.11.3 For youth who screened positively on the initial risk screen, but who do not complete Enrollment in CSoC, the Contractor shall offer participation in the Case Management Program, and/or other behavioral health services to meet the child and family's presenting needs.

2.12.11.4 Upon request, the Contractor shall provide LDH with documentation supporting how it has placed appropriate limits on a service on the basis of medical necessity for individuals determined by LDH to need SBHS.

2.12.12 PRTF Requirements

2.12.12.1 Pre-screen for PRTF

Deleted: <#>The Contractor shall maintain a written strategy for conducting health record reviews, reporting results and the corrective action process. The strategy shall be provided to LDH or its designee for approval as part of Readiness Review and sixty (60) Calendar Days prior to the implementation of any updates. 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 Contractor shall use to review each site; ¶
<#>How the Contractor shall link the information compiled during the review to other Contractor functions (e.g. quality improvement [QI], credentialing, peer review, etc.); and ¶
<#>Schedule of reviews by provider type.

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2.12.12.1.1 When a referring party requests PRTF for an Enrollee, the Contractor shall perform an initial screen upon receipt of referral including review of records , inclusive of MCO records of the history of outpatient and inpatient treatment authorizations and services, records the MCO has requested and obtained from treatment providers for which the MCO was the payer, and current clinical information to determine whether PRTF is an appropriate level of care, or if alternate community-based services could meet the referral needs. If a parent, guardian, or referring party initially submits information lacking in sufficient detail to make a determination of medical necessity, the MCO shall make a request for the necessary information and/or documentation and allow time for satisfaction of the request prior to issuing a denial. The screen shall be completed within twenty-four (24) hours of the Contractor's receipt of the referral and all clinical information needed and requested by the Contractor to make the determination.

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2.12.12.1.2 Upon completion of the screen, if the PRTF is approved, the Contractor shall immediately notify the Enrollee and/or guardian and, with consent, the referring party requesting PRTF services and, within forty-eight (48) hours, provide written notification of the approval. The Contractor shall also then generate a Prior Authorization for each PRTF admission within forty-eight (48) hours of completion of the screen. In consultation with the Enrollee's guardian and referring party, the Contractor shall locate a PRTF provider appropriate to meet the Enrollee's needs with availability to admit the Enrollee. Given the need to locate an appropriate PRTF provider with bed availability in a Timely manner, the Contractor shall maintain near real time bed utilization/availability for network PRTFs and out-of-network replacements. When the initial screen results in a determination that the Enrollee is in need of PRTF care, the Contractor shall secure admission to an appropriate PRTF for the Enrollee within the timeframe stated in Attachment F, *Provider Network Standards*, in compliance with access and availability standards for this level of care.

2.12.12.1.3 If PRTF placement is denied, the Contractor shall immediately notify the Enrollee and/or guardian and, with consent, the referring party requesting PRTF services and, within forty-eight (48) hours, provide written notification of the denial. The notification of denial shall include information on alternative services that may meet the Enrollee's needs to ensure health and safety, including information on available providers of those services, the right of the Enrollee to Appeal the denial, and the process to do so. When a PRTF denial is issued for a youth currently in an out-of-home setting (including but not limited to hospital or detention), upon issuing the denial the MCO shall at the same time initiate contact with the parent/guardian, referring party, and current treating provider to coordinate, gain consent, and arrange for the recommended alternative services, to ensure continuity of care.

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2.12.12.1.4 For youth pending release from a secure setting for whom a PRTF is being requested, the Contractor is required to complete the screen prior to the youth's release if it is anticipated that the youth will be re-linked to the Contractor following release.

2.12.12.2 Certification of Need (CON) for PRTFs

2.12.12.2.1 The Contractor shall comply with the requirements set forth at 42 CFR Part 441, Subpart D.

2.12.12.2.2 The Contractor shall ensure LMHPs are included in the team responsible for certification and recertification of PRTF services in Louisiana. This shall include a face-to-face assessment by an LMHP or a telephonic/video consultation with an LMHP who has had a face-to-face interview with the child/youth, in addition to the recommendations of the team specified at 42 CFR §441.156.

2.12.12.2.3 The Contractor may use an LMHP/team composed of Contractor staff or subcontracted LMHPs. To ensure the team has knowledge of the ambulatory resources available to the youth and the youth's situation, the Contractor shall ensure that the team is assembled by a subcontract in the child's/youth's parish of residence or adjacent parish (if not in state custody) or the child's/youth's parish or adjacent parish of responsibility (if in State custody).

2.12.12.2.4 For youth pending release from a secure setting for whom a PRTF is being requested, the Contractor is required to coordinate the completion of the CON prior to the youth's release if it is anticipated that the youth shall be re-linked to the Contractor following release.

2.12.12.2.5 Recertification of the stay shall occur every sixty (60) Calendar Days. For the PRTF screens to be complete, the team shall meet and rule out other community based options. This does not apply to other inpatient screens.

2.12.12.3 In addition to the pre-screen and certifying the need, the Contractor shall:

2.12.12.3.1 Be responsible for tracking the Enrollee's authorization period for PRTF stays and providing notification to the Authorized Representative when a recertification is due;

2.12.12.3.2 Ensure that PRTF certification, including the independent certification, are forwarded to the admitting facility;

2.12.12.3.3 Accurately determine admissions and discharges to PRTFs and perform PRTF-specific eligibility functions; and

2.12.12.3.4 Work with the FI to determine retroactive eligibility and assignment, when applicable.

2.12.13 Clinical Practice Guidelines

2.12.13.1 The Contractor shall comply with the requirements specified in 42 CFR § 438.236.

2.12.13.2 Clinical practice guidelines refer to educational materials that consist of best practices and evidence-based standards. Clinical practice guidelines are distinct from authorization criteria and shall not be used to make coverage, medical necessity, or reimbursement determinations.

2.12.13.3 The Contractor shall adopt clinical practice guidelines for at least the conditions listed below:

2.12.13.3.1 Schizophrenia;

2.12.13.3.2 ADHD;

2.12.13.3.3 Autism Spectrum Disorder;

2.12.13.3.4 Depression;

2.12.13.3.5 Generalized Anxiety Disorder;

2.12.13.3.6 Post-Traumatic Stress Disorder;

2.12.13.3.7 Suicidal Behavior;

2.12.13.3.8 Oppositional Defiant Disorder;

2.12.13.3.9 Bipolar Disorder; and

2.12.13.3.10 Substance Use Disorders.

2.12.13.4 The Contractor shall adopt clinical practice guidelines that meet the following requirements:

2.12.13.4.1 Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.

2.12.13.4.2 Consider the needs of the Contractor's Enrollees.

2.12.13.4.3 Are adopted in consultation with network providers.

2.12.13.4.4 Are reviewed and updated periodically as appropriate.

2.12.13.5 The Contractor shall disseminate the clinical practice guidelines to all affected providers and, upon request, to Enrollees and Potential Enrollees.

2.12.13.6 The Contractor shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the clinical practice guidelines.

2.12.13.7 The Contractor should coordinate the development of clinical practice guidelines with other MCOs where appropriate to avoid providers receiving conflicting guidelines from different MCOs.

2.12.13.8 The Contractor should encourage adoption of the clinical practice guidelines by providers and measure compliance with the guidelines through provider monitoring.

2.12.13.9 The Contractor should employ provider incentive strategies, such as financial and non-financial incentives, to improve compliance.

2.13 Enrollee Services

2.13.1 Enrollees' Rights and Responsibilities

2.13.1.1 The Contractor shall have written policies regarding Enrollee rights and responsibilities. The Contractor shall comply with all applicable Federal and State laws, regulations, rules, policies, procedures, and manuals pertaining to Enrollee rights and privacy. The Contractor shall further ensure that the Contractor's employees, Subcontractors and providers consider and respect those rights when providing services to Enrollees.

2.13.1.2 The rights afforded to current Enrollees are detailed in the **MCO Manual**.

2.13.1.3 The Contractor shall encourage each Enrollee to be responsible for his/her own health care by becoming an informed and active participant in his/her care. Enrollees have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate medical and personal histories, being present at scheduled appointments and reporting on treatment progress, such as notifying his/her health care provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.

2.13.1.4 The Contractor shall inform Enrollees of their responsibilities which shall include, but are not limited to:

2.13.1.4.1 Informing the Contractor of the loss or theft of their MCO Member ID Card;

2.13.1.4.2 Presenting their MCO Member ID Card when using health care services;

2.13.1.4.3 Being familiar with the Contractor's procedures to the best of the Enrollee's abilities;

2.13.1.4.4 Calling or contacting the Contractor to obtain information and have questions answered;

2.13.1.4.5 Providing participating Network Providers with accurate and complete medical information;

2.13.1.4.6 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;

2.13.1.4.7 Living healthy lifestyles and avoiding behaviors known to be detrimental to their health;

2.13.1.4.8 Following the Grievance system established by the Contractor if they have a disagreement with a provider; and

2.13.1.4.9 Making every effort to keep any agreed upon appointments and follow-up appointments, accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.

2.13.2 Required Materials and Services

2.13.2.1 The Contractor shall ensure materials do not discriminate against Enrollees on the basis of their health history, health status or need for health care services. This applies to Enrollment, reenrollment or Disenrollment materials and processes from the Contractor.

2.13.2.2 The Contractor shall adhere to the requirements and procedures regarding the justice-involved pre-release population as set forth in the **Justice-Involved Pre-Release Enrollment Program Manual**.

2.13.2.3 The Contractor shall adhere to the requirements for the Member Handbook, Welcome Member Newsletter, MCO Member ID Card, and Provider Directory as specified in this Contract, its attachments, and in accordance with 42 CFR §438.10.

2.13.3 Welcome Packets

2.13.3.1 The Contractor shall send a welcome packet to new Enrollees within ten (10) Business Days from the date of receipt of the ASC X12N 834 Benefit Enrollment and Maintenance electronic transaction file identifying the new Enrollee. MCO Member ID Cards must be mailed within ten (10) Business Days.

2.13.3.2 When the name of the Authorized Representative for the new Enrollee is associated with two (2) or more new Enrollees in the same eligibility group (see *Eligibility and Enrollment* section), the Contractor is only required to send one (1) welcome packet. If Enrollees are in different eligibility groups that equate to different levels of coverage, separate welcome packets for each type of coverage shall be sent.

2.13.3.3 All contents of the welcome packet are considered Member Materials and, as such, shall be reviewed and subject to written approval by LDH prior to distribution according to the provisions described in this Contract. Contents of the welcome packets shall include those items specified in the Contract. The welcome packet shall include, but is not limited to:

2.13.3.3.1 Welcome Member Newsletter;

2.13.3.3.2 The MCO Member ID Card (if not mailed under a separate mailing); and

2.13.3.3.3 If the MCO Member ID Card is mailed separately, a Welcome Letter highlighting major program features, details that the MCO Member ID Card shall be sent via mail separately, and contact information for the Contractor.

2.13.4 Welcome Calls

2.13.4.1 The Contractor shall make welcome calls to new Enrollees within fourteen (14) Business Days of the date the Contractor sends the welcome packet.

2.13.4.2 The Contractor shall review PCP assignment if a PCP Automatic Assignment was made and assist the Enrollee in changing the PCP if requested by the Enrollee.

2.13.4.3 The Contractor shall develop and submit to LDH for approval a script(s), for all covered populations as specified in the *Eligibility and Enrollment* section to be used during the welcome call to discuss the following information with the Enrollee:

2.13.4.3.1 A brief explanation of the program;

2.13.4.3.2 Statement that all Enrollee PHI shall be handled in accordance with Federal and State privacy laws;

2.13.4.3.3 The availability of oral interpretation and written translation services and how to obtain them free of charge;

2.13.4.3.4 The concept of the patient-centered medical home, including the importance of the Enrollee(s) making a first appointment with his or her PCP for preventive care before the Enrollee requires care due to an illness or condition and instructions about changing PCPs; and

2.13.4.3.5 Administration of the Health Needs Assessment with a focus on criteria to establish the appropriate tier of case management as described in the *Care Management* section.

2.13.4.4 The Contractor shall make three (3) attempts to contact the Enrollee. If the Contractor discovers that the Enrollee lost or never received the welcome packet, the Contractor shall resend the packet.

2.13.4.5 Health Needs Assessment

2.13.4.5.1 The Contractor shall attempt to conduct Enrollee Health Needs Assessments (HNA) as part of the Enrollee welcome call to identify health and functional needs of Enrollees, and to identify Enrollees who require short-term care coordination or Case Management for medical, behavioral or social needs. When an Enrollee is a child, the HNA shall be completed by the Enrollee's parent or legal guardian.

2.13.4.5.2 The Contractor shall develop, implement, and maintain procedures for completing an initial HNA for each Enrollee, and shall make best efforts to complete such screening within ninety (90) Calendar Days of the Enrollee's effective date of Enrollment [42 CFR §438.208(b)]. If the initial HNA attempt is unsuccessful, the Contractor shall attempt to conduct, and document its efforts to conduct, the HNA on at least three (3) different occasions, at different times of the day and on different days of the week.

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

2.13.4.5.4 The Contractor's HNA shall:

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

2.13.4.5.4.2 Be made available to Enrollees in multiple formats including web-based, print, and telephone;

2.13.4.5.4.3 Be conducted with the consent of the Enrollee;

2.13.4.5.4.4 Identify individuals for referral to Case Management;

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

2.13.4.5.4.6 Include disclosures of how information will be used.

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2.13.5 Member Materials and Programs for Current Enrollees

The Contractor shall develop and distribute member educational materials, including but not limited to, the following:

2.13.5.1 An Enrollee-focused website which can be a designated section of the Contractor's general informational website, and interactive media content such as a mobile device application, a mobile optimized website, or interactive social media;

2.13.5.2 Bulletins or newsletters distributed not less than two (2) times per calendar year that provide information on preventive care, access to PCPs and other providers, and other information that is helpful to Enrollees;

2.13.5.3 Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the Contractor. This would also include, but not be limited to, EPSDT outreach materials and Enrollee appointment and preventive testing reminders;

2.13.5.4 Targeted brochures, posters and pamphlets to address issues associated with Enrollees with chronic diseases and/or special heath care needs;

2.13.5.5 Materials focused on health promotion programs available to the Enrollees;

2.13.5.6 Communications detailing how Enrollees can take personal responsibility for their health and self-management;

2.13.5.7 Materials that promote the availability of health education classes for Enrollees;

2.13.5.8 Materials that provide education for Enrollees with, or at risk for, a specific disability or illness;

2.13.5.9 Materials that provide education to Enrollees, Enrollees' families and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities;

2.13.5.10 Notification to its Enrollees of their right to request and obtain the welcome packet (including all items noted in this section except for the MCO Member ID card) at least once a year;

2.13.5.11 Notification to its Enrollees of any change that LDH defines as significant at least thirty (30) Calendar Days before the intended effective date; and

2.13.5.12 All materials distributed must comply with the relevant guidelines established by LDH for these materials and/or programs.

2.13.6 Member Handbook

2.13.6.1 The Contractor shall provide each Enrollee a Member Handbook, utilizing the State developed model Member Handbook in the **Marketing and Member Education Companion Guide**, to serve as a summary of benefits and coverage, with the welcome packet. [42 CFR §438.10]

2.13.6.2 At a minimum, the Member Handbook shall include the following information, as applicable to the covered population that is the audience for the Member Handbook, that enables the Enrollee to understand how to effectively use the Managed Care Program:

2.13.6.2.1 Table of contents;

2.13.6.2.2 A general description about how the Contractor operates, and detailed descriptions of the following: Enrollee rights and responsibilities, appropriate utilization of services including ED for non-emergent conditions, behavioral health services available, a description of the PCP selection process, the PCP's role as coordinator of services, and an explanation of how the Enrollee can access LDH's policy on how to receive continued services during a termination of the Contract or Disenrollment from an MCO as required by 42 CFR §438.62;

2.13.6.2.3 Enrollee's right to disenroll from the Contractor including Disenrollment for cause;

2.13.6.2.4 Enrollee's right to select and change PCPs and other health care professionals within the Contractor's provider network and how to do so;

2.13.6.2.5 Any restrictions on the Enrollee's freedom of choice among Network Providers;

2.13.6.2.6 Enrollee's rights and protections, as specified in 42 CFR §438.100 and this Contract;

2.13.6.2.7 The amount, duration, and scope of benefits available to the Enrollee under this Contract in sufficient detail to ensure that Enrollees understand the benefits to which they are entitled, including specialized behavioral health benefits and information about health education and promotion programs, including Care Management, tobacco cessation, and problem gaming;

2.13.6.2.8 Procedures for obtaining benefits, including authorization requirements;

2.13.6.2.9 Description on the purpose of the Medicaid ID Card and the MCO Member ID Card and why both are necessary and how to use them;

2.13.6.2.10 The extent to which, and how, Enrollees may obtain benefits, including family planning services from out-of-Network Providers. An explanation shall be included that explains that the Contractor cannot require the Enrollee to obtain a referral before choosing a family planning provider;

2.13.6.2.11 The extent to which, and how, after-hours, crisis and emergency coverage are provided, including:

2.13.6.2.11.1 What constitutes an Emergency Medical Condition, Emergency Services, and post-stabilization services, as defined in 42 CFR §438.114(a);

2.13.6.2.11.2 That Prior Authorization is not required for Emergency Services;

2.13.6.2.11.3 The process and procedures for obtaining Emergency or Crisis Response Services, including use of the LCH, 911-telephone system or its local equivalent;

2.13.6.2.11.4 The locations of any emergency settings and other locations at which providers and hospitals furnish Emergency Services, crisis response services, and post-stabilization services covered by the Contractor; and

2.13.6.2.11.5 That, subject to the provisions of 42 CFR Part 438, the Enrollee has a right to use any hospital or other setting for emergency care.

2.13.6.2.12 The post-stabilization care services rules set forth in 42 CFR §422.113(c);

2.13.6.2.13 Policy on referrals for specialty care, including SBHS and for other benefits not furnished by the Enrollee's PCP;

2.13.6.2.14 How and where to access any benefits that are available under the State Plan, but are not covered under the Contract;

2.13.6.2.15 That the Enrollee has the right to refuse to undergo any medical service, or treatment or to accept any health service provided by the Contractor if the Enrollee objects (or in the case of a child, if the parent or guardian objects) on religious grounds;

2.13.6.2.16 For counseling or referral services that the Contractor does not cover because of moral or religious objections, the Contractor shall direct the Enrollee to contact the Enrollment Broker for information on Disenrollment procedures;

2.13.6.2.17 Enrollee Grievance, Appeal, and State Fair Hearing procedures and time frames, as described in 42 CFR Part 438, Subpart F and this Contract;

2.13.6.2.18 Grievance, Appeal, and State Fair Hearing procedures that include the following:

2.13.6.2.18.1 For State Fair Hearing:

The right to a hearing;

The method for obtaining a hearing; and

The rules that govern representation at the hearing.

2.13.6.2.18.2 The right to file Grievances and Appeals;

2.13.6.2.18.3 The requirements and timeframes for filing a Grievance or Appeal;

2.13.6.2.18.4 The availability of assistance in the filing process;

2.13.6.2.18.5 The toll-free numbers that the Enrollee can use to file a Grievance or an Appeal by phone;

2.13.6.2.18.6 The fact that, when requested by the Enrollee:

Benefits will continue if the Enrollee files an Appeal or a request for State Fair Hearing within the timeframes specified for filing; and

The Enrollee may be required to pay the cost of services furnished while the Appeal is pending, if the final decision is adverse to the Enrollee.

2.13.6.2.18.7 In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of the LDH who has final authority to determine whether services shall be provided.

2.13.6.2.19 Advance Directives, as set forth in 42 CFR §438.3(j). A description of Advance Directives which shall include:

2.13.6.2.19.1 The Contractor's policies related to Advance Directives;

2.13.6.2.19.2 The Enrollee's rights under State law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate Advance Directives; any changes in law shall be reflected in the Member Handbook as soon as possible, but no later than ninety (90) Calendar Days after the effective date of the change;

2.13.6.2.19.3 Information on how Enrollees can file complaints about the failure to comply with an Advance Directive with the LDH Health Standards Section, Louisiana's Survey and Certification agency; and

2.13.6.2.19.4 Information about where an Enrollee can seek assistance in executing an Advance Directive and to whom copies should be given.

2.13.6.2.20 Information on how to call the Medicaid Customer Service Unit toll-free hotline, visit the Louisiana Medicaid Program website, or visit a regional Louisiana Medicaid Program eligibility office to report any changes to demographic or other information which may affect eligibility;

2.13.6.2.21 Information on how to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";

2.13.6.2.22 A description of Enrollee Services and the toll-free number, fax number, e-mail address and mailing address to contact Enrollee Services;

2.13.6.2.23 The toll-free telephone number for medical management;

2.13.6.2.24 How to obtain emergency and NEMT, including transportation for any benefits carved out of the Contract and provided by the State;

2.13.6.2.25 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and how to access component services if individuals under age twenty-one (21) entitled to the EPSDT benefit are enrolled with the Contractor;

2.13.6.2.26 How and where to access any benefits provided by the State, including EPSDT and dental benefits delivered outside the Contractor;

2.13.6.2.27 Information about cost sharing on any benefits carved out of the Contract and provided by the State;

2.13.6.2.28 Information about the requirement that an Enrollee shall notify the Contractor immediately if he or she has a Worker's Compensation claim, a pending personal injury or medical malpractice lawsuit, or has been involved in an automobile accident;

2.13.6.2.29 Reporting requirements for the Enrollee that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported to the Contractor;

2.13.6.2.30 Enrollee responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Contractor or LDH. This shall include a statement that the Enrollee is responsible for protecting their MCO Member ID Card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the Enrollee's Louisiana Medicaid Program eligibility and/or legal action;

2.13.6.2.31 Instructions on how to access auxiliary aids and services, including interpretation and translation in alternative formats and languages when needed at no cost to the Enrollee. This instruction shall be included in all versions of the Member Handbook in English and Spanish;

2.13.6.2.32 Information on the Enrollee's right to a second opinion in accordance with 42 CFR §438.206(b)(3) at no cost and how to obtain it;

2.13.6.2.33 Ways to report suspected provider Fraud and Abuse including, but not limited to, using the LDH and Contractor toll-free numbers and website established for that purpose;

2.13.6.2.34 Any additional text provided to the Contractor by LDH in writing or deemed essential by the Contractor;

2.13.6.2.35 The date of the last revision;

2.13.6.2.36 Additional information that is available upon request, including the following:

2.13.6.2.36.1 Information on the structure and operation of the Contractor;

2.13.6.2.36.2 Physician incentive plans [42 CFR §438.3(i)].

2.13.6.2.36.3 Service utilization policies; and

2.13.6.2.36.4 How to report alleged Marketing violations to LDH utilizing the **Marketing Complaint Form,** which can be found in the **Marketing and Member Education Companion Guide**.

2.13.6.2.37 Information regarding SBHS, including, but not limited to:

2.13.6.2.37.1 A description of covered behavioral health services;

2.13.6.2.37.2 Where and how to access behavioral health services and behavioral health providers;

2.13.6.2.37.3 General information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult engagement; resilience; strength-based and evidence-based practice; and best/proven practices;

2.13.6.2.37.4 Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and

2.13.6.2.37.5 Any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment as per 42 CFR Part 2.

2.13.6.2.38 Information on what to do if an Enrollee is billed, and under what circumstances an Enrollee may be billed for non-MCO Covered Services;

2.13.6.3 The information specified in this Section for the Member Handbook will be considered to be provided if the Contractor:

2.13.6.3.1 Mails a printed copy of the information to the Enrollee's mailing address;

2.13.6.3.2 Provides the information by email after obtaining the Enrollee's agreement to receive the information by email;

2.13.6.3.3 Posts the information on their Enrollee website and advises the Enrollee in paper or electronic form that the information is available at the specified web address, provided that Enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or

2.13.6.3.4 Provides the information in any other method that can reasonably be expected to result in the Enrollee receiving the information.

2.13.6.4 At least once a year, the Contractor shall notify the Enrollee of their option of receiving either the Member Handbook or the Member Welcome Newsletter, and the Provider Directory, in either electronic format or hardcopy, upon request from the Enrollee.

2.13.6.5 The Contractor shall review and update the Member Handbook at least once a year. The Member Handbook shall be submitted to LDH for approval at least once a year and upon any changes prior to the updated version being made available to Enrollees.

2.13.6.6 Welcome Newsletter

2.13.6.6.1 The Contractor shall develop and maintain a Welcome Newsletter that adheres to the requirements in 42 CFR §438.10.

2.13.6.6.2 The Contractor shall review and update the Welcome Newsletter at least once a year. The newsletter must be submitted to LDH for approval at least once a year and upon any changes prior to the updated version being made available to Enrollees.

2.13.6.6.3 At a minimum, each Welcome Newsletter shall include the following information as it applies to the covered populations as specified in the *Eligibility and Enrollment* section:

2.13.6.6.3.1 Right to request an updated Member Handbook at no cost to the Enrollee. Notification that the Member Handbook is available on the Contractor's website, by electronic mail or through postal mailing must be referenced;

2.13.6.6.3.2 Enrollee Grievance and Appeal rights;

2.13.6.6.3.3 Right to access oral interpretation services, free of charge, and how to access them that adheres to the requirements in 42 CFR §438.10(d)(4) and (5);

2.13.6.6.3.4 Contractor service hours and availability with contact information including, but not limited to, Enrollee Services, Nurse Line, reporting suspected Fraud and Abuse, Pharmacy Benefits Manager, and any Subcontractor providing MCO Covered Services or Value-Added Benefits;

Deleted: Behavioral Health Crisis Line,

2.13.6.6.3.5 Tobacco Cessation Information with a website link to tobacco education and prevention program;

2.13.6.6.3.6 Information on how to search for providers, including specialized behavioral health providers, and how to obtain, at no charge, a directory of providers;

2.13.6.6.3.7 Information regarding the circumstances under which an Enrollee may be billed for non-MCO Covered Services;

2.13.6.6.3.8 What to do in case of an emergency, information on proper emergency service utilization, and the right to obtain Emergency Services at any hospital or other ED facility, in or out-of-network;

2.13.6.6.3.9 Description of Fraud, Waste, and Abuse, including instruction on how to report suspected Fraud, Waste, and Abuse;

2.13.6.6.3.10 Right to be treated fairly regardless of race, religion, age, sexual orientation, and ability to pay;

2.13.6.6.3.11 Right to request a medical record copy and/or inspect medical records at a reasonable, cost-based fee as specified in 45 CFR §164.524;

2.13.6.6.3.12 How to access after-hours care;

2.13.6.6.3.13 How to change MCOs;

2.13.6.6.3.14 Instructions on changing your PCP;

2.13.6.6.3.15 Instructions on where to find detailed listing of covered benefits;

2.13.6.6.3.16 Identification of services for which copays are applicable;

2.13.6.6.3.17 SBHS information, including where and how to access behavioral health services (including emergency or crisis services); and

2.13.6.6.3.18 Problem gambling treatment with a website link to resources.

2.13.7 Member Identification (ID) Cards

2.13.7.1 Enrollees shall be issued up to three (3) different MCO Member ID cards related to their Enrollment in the Managed Care Program.

2.13.7.1.1 A Medicaid ID Card shall be issued to all Beneficiaries, including Enrollees. This card is not proof of eligibility, but can be used by providers to access the State's electronic eligibility verification systems. These systems will contain the most current information available to LDH, including specific information regarding Enrollment. There will be no Contractor specific information printed on the card. The Enrollee may need to show this card to access Medicaid Covered Services not included in the MCO Covered Services.

2.13.7.1.2 A Dental Benefit Program Manager (DBPM) issued ID card will be issued to all eligible Enrollees. It will be used by Enrollees to access dental benefits provided through the DBPM.

2.13.7.1.3 The Contractor shall issue an MCO Member ID Card to its Enrollees. The MCO Member ID Card must be clearly legible with a minimum font size of six (6) points, preferably eight (8) points, and shall comply with guidance from the Workgroup for Electronic Data Interchange (WEDI) Health Identification Card Implementation Guide. Exceptions due to space constraints may be considered on case by case basis and must be approved, in writing, by LDH. The Contractor shall design and, upon approval by LDH in writing, produce, and distribute MCO Member ID Cards. The MCO Member ID Card shall contain information specific to the Contractor and be easily and readily distinguishable from all other insurance products operated by the Contractor or its parent corporation. The MCO Member ID Card shall at a minimum include, but not be limited to, the

following information as it applies to the covered populations as specified in the *Eligibility and Enrollment* section:

2.13.7.1.3.1 The Contractor's name, or identifying trademark, ~~and~~ address, and identifier (plan ID);

2.13.7.1.3.2 The Enrollee's name;

2.13.7.1.3.3 The Member ID Number, which shall be a unique identifying number assigned by the Contractor;

2.13.7.1.3.4 The PCP's name, address, and telephone number(s) (including after-hours number, if different from business hours number);

2.13.7.1.3.5 The PBM's name, or identifying trademark, and address;

2.13.7.1.3.6 RxBIN and other electronic transaction routing information and other numbers required by the Contractor or the PBM to process a drug Claim electronically, including, but not limited to, the RxPCN, RxGRP, or RXID, including FFS information for Enrollees enrolled for Specialized Behavioral Health and NEMT and/or NEAT services only;

2.13.7.1.3.7 The Member ID Number encoded into a standard 2D, QR machine-readable barcode and printed with a minimum ¾" height and width;

2.13.7.1.3.8 Instructions for emergencies; and

2.13.7.1.3.9 The toll-free number(s) for:
The 24-hour Nurse Line;
The Member Services Line;
The Louisiana Crisis Hub line;
Filing Appeals and Grievances;
Provider services and Prior Authorization;
Pharmacy benefit assistance;
Pharmacy services and Prior Authorization; and
Reporting Medicaid Fraud (1-800-488-2917).

2.13.7.1.4 LDH may grant exceptions to the required content of the MCO Member ID Card due to space constraints on case-by-case basis. Exceptions must be approved in writing by LDH.

2.13.7.1.5 The Contractor shall not include the Enrollee's date of birth on MCO Member ID Cards.

2.13.7.1.6 The Contractor shall utilize two-factor and dynamic knowledge-based authentication before details about the Enrollee are discussed over the phone. Information used to authenticate the Enrollee shall not include information that can be found on their MCO Member ID Card.

2.13.7.2 The Contractor shall ensure that its Subcontractors can identify Enrollees in a manner which shall not result in discrimination against the Enrollees, in order to provide or coordinate the provision of all MCO Covered Services and/or VAB and out-of-network services.

2.13.7.3 The Contractor may provide the MCO Member ID Card in a separate mailing from the welcome packet, however the card shall be sent no later than ten (10) Business Days from the date of receipt of the ASC X12N 834 Benefit Enrollment and Maintenance electronic transaction file from LDH or the Enrollment Broker identifying the new Enrollee. As part of the welcome packet information, the Contractor shall explain the purpose of the card, how to use the card, and how to use it in tandem with the Medicaid ID Card. The Contractor shall distribute cards for justice-involved pre-release Enrollees in accordance with the **Justice-Involved Pre-Release Enrollment Program Manual**. LDH reserves the right to assess Monetary Penalties for failure to meet this requirement.

2.13.7.4 The MCO Member ID Card shall be issued without the PCP information if no PCP selection has been made as of the date of the mailing.

2.13.7.5 Once PCP selection has been made by the Enrollee or through PCP Automatic Assignment, the Contractor shall reissue the MCO Member ID Card in keeping with the time guidelines in this Contract. As part of the mailing of the reissued MCO Member ID Card, the Contractor shall explain the purpose of the reissued card, the changes between the new card and the previous card, and what the Enrollee should do with the previous card.

2.13.7.6 The Contractor shall reissue the MCO Member ID Card within ten (10) Calendar Days of notice that an Enrollee reports a lost or stolen card, there is an Enrollee name change, the PCP changes, or for any other reason that results in a change to the information on the MCO Member ID Card.

2.13.7.7 The holder of the MCO Member ID Card issued by the Contractor shall be an Enrollee or guardian of an Enrollee. If the Contractor has knowledge of any Enrollee permitting the use of the MCO Member ID Card by any other person, the Contractor shall immediately report this violation to the Louisiana Medicaid Program Fraud Hotline number: 1-800-488-2917.

2.13.7.8 The Contractor shall engage with LDH's designee to provide Enrollees with digital access to MCO Member ID Cards through the LA Wallet mobile app.

2.13.8 Provider Directory for Enrollees

2.13.8.1 The Contractor shall develop and maintain a Provider Directory in three (3) formats:

2.13.8.1.1 A hard copy directory, a copy of which shall be provided to Enrollees and Potential Enrollees upon request;

2.13.8.1.2 Web-based machine readable and searchable, mobile-enabled, online directory for Enrollees and the public; and

2.13.8.1.3 Electronic file of the directory to be submitted and updated weekly to the FI, the Enrollment Broker, or other designee as determined by LDH.

2.13.8.2 The Contractor shall submit templates of its Provider Directory to LDH or its designee as part of Readiness Review.

2.13.8.3 The Contractor shall provide the Provider Directory in a manner agreeable to the Enrollee either by mail or by utilizing the Contractor's website. The Contractor shall distribute information regarding provider directories to new Enrollees within thirty (30) Calendar Days of receipt of notification of Enrollment. Such information shall include how to access the Provider Directory, including the right to request a hard copy and to contact the Contractor's Enrollee services line to inquire regarding a provider's participation in the network. Enrollees receiving a hard copy of the Provider Directory shall be advised that the network may have changed since the directory was printed and how to access current information regarding the Network Providers.

2.13.8.4 The hard copy directory for Enrollees shall be revised with updates at least quarterly. Inserts may be used to update the hard copy directories monthly to fulfill requests by Enrollees and Potential Enrollees. The web-based online version shall be updated in real time, but no less than weekly.

2.13.8.5 The online directory shall be made readily accessible to Enrollees. This means the directory shall have a clearly identifiable link or tab and shall not require an Enrollee account or policy number to access the directory. The directory must accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

2.13.8.6 The Contractor shall include, in both electronic and paper directories, a customer service email address, telephone number and/or electronic link

that individuals may use to notify the Contractor of inaccurate Provider Directory information.

2.13.8.7 In accordance with 42 CFR §438.10(h), the Provider Directory shall include, but not be limited to:

2.13.8.7.1 Identification of qualified Network Providers divided into specific provider and service types and specializations, including but not limited to, PCPs, specialists, hospital PCP groups, pharmacies, behavioral health providers, clinic settings, home and community-based services, outpatient therapy, residential substance use, youth residential services, inpatient mental health and residential substance use services, and FQHCs and RHCs in the service area. This shall include a child serving Provider list that is both monitored and frequently updated to ensure viable options are identified and available for OJJ, DCFS and LDOE field staff. Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified. Providers specializing in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related and postpartum substance use disorders shall be clearly identified. Provider types shall be delineated by parish and zip code;

2.13.8.7.2 Names, group affiliations, street addresses, telephone numbers, website URLs, specialties, whether the provider is accepting new Enrollees, whether the provider offers covered services via telehealth and cultural and linguistic capabilities by current Network Providers by each provider type specified in this Contract. Cultural and linguistic capabilities shall include languages offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competency training. The Provider Directory shall also indicate whether the Network Provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment;

2.13.8.7.3 Note of Prior Authorization or referral requirement for Network Providers, if applicable;

2.13.8.7.4 Identification of any restrictions on the Enrollee's freedom of choice among Network Providers;

2.13.8.7.5 Identification of hours of operation including identification of providers with non-traditional hours (before 8 a.m. or after 5 p.m., Central Time, or any weekend hours);

2.13.8.7.6 Identification of pharmacies that provide vaccine services and delivery services;

2.13.8.7.7 Instructions for the Enrollee to contact the Contractor's toll free Enrollee services telephone line for assistance in finding a Network Provider or a convenient pharmacy;

2.13.8.7.8 Customer service email address, telephone number, and/or electronic link that individuals may use to notify the Contractor of inaccurate Provider Directory information; and

Deleted: <#>The hard copy and online Provider Directories shall not include Network Providers who have submitted no Claims within the six (6) calendar months prior to publication, unless the Network Provider was newly contracted during this six (6) month period;

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2.13.8.7.9 Network Provider's gender, race, and ethnicity, if available.

2.13.8.8 LDH reserves the right to request in writing additional data needed for enhancements to the provider search function.

2.13.8.9 The Contractor shall audit Provider Directory information for accuracy in accordance with this Contract and the **MCO System Companion Guide** for all PCPs, OB/GYNs, hospitals, and behavioral health providers at least quarterly, and audit at least a statistically valid sample size of its Provider Directory information on a more frequent, periodic basis. Documentation of such audits shall be retained and made available to LDH upon request.

2.13.8.10 LDH reserves the right to conduct periodic audits to verify the accuracy of the Contractor's Provider Directory data. LDH will utilize full discretion in determining the audit type, criteria, and methodology. LDH may penalize the Contractor for inaccurate Provider Directories using one (1) or more remedies in the *Contract Non-Compliance* section and Attachment G, *Table of Monetary Penalties*.

2.13.9 Notice to Enrollees of Provider Termination

2.13.9.1 The Contractor shall develop a notification template, to be approved by LDH in writing, informing Enrollees of provider terminations. The notice shall be mailed to each impacted Enrollee.

2.13.9.1.1 If the Contractor terminates a Network Provider Agreement without cause, the notification shall also inform the Enrollee of their ability to change their MCO and include a pre-paid return envelope.

2.13.9.2 The Contractor shall give written notice of a provider's termination to each Enrollee who received care from the terminated provider within the last eighteen (18) months. When Timely notice from the provider is received or when the Contractor initiates the termination, the notice to the Enrollee shall be provided by the later of 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.

2.13.9.2.1 The Contractor shall also give written notice of a provider's termination to the State agency, as appropriate, that has been involved in the care of an impacted Enrollee.

2.13.9.3 Failure to provide notice prior to the dates of termination shall be allowed when the provider becomes unable to care for Enrollees due to illness, the provider dies, the provider moves from the service area and fails to notify the Contractor, the provider fails credentialing or is displaced as a result of a natural or man-made disaster, or for any other reason determined sufficient by LDH in writing. Under these circumstances, notice shall be issued immediately upon the Contractor becoming aware of the circumstances.

2.13.10 Enrollee Call Center

2.13.10.1 The Contractor shall maintain a toll-free Enrollee service call center, physically located in the United States, with dedicated staff to respond to Enrollee questions including, but not limited to, such topics as:

2.13.10.1.1 Explanation of MCO policies and procedures;

2.13.10.1.2 Prior Authorizations;

2.13.10.1.3 Access information;

2.13.10.1.4 Information on PCPs or specialists;

2.13.10.1.5 Referrals to participating specialists;

2.13.10.1.6 Resolution of service and/or medical or behavioral health delivery problems;

2.13.10.1.7 Enrollee rights and responsibilities;

2.13.10.1.8 Coordination of support services available through the Louisiana Medicaid Program or community organizations;

2.13.10.1.9 Enrollee Grievances; and

2.13.10.1.10 Information on SBHS and Providers.

2.13.10.2 The toll-free number must be staffed on Business Days between the hours of 7 a.m. and 7 p.m. Central Time.

2.13.10.3 The toll-free line shall have an automated system, available twenty-four (24)-hours a day, seven (7) days a week. This automated system shall include the capability of providing callers with operating instructions on what to do in case of an emergency and the option to talk directly to a nurse or other clinician or leave a message, including instructions on how to leave a message and when that message will be returned. The Contractor shall ensure that the voice mailbox has adequate capacity to receive all messages and that Enrollee services staff return all calls by close of business the following Business Day.

2.13.10.4 The toll-free phone line shall be accessible by all Enrollees, regardless of whether they are calling about physical health or behavioral health. The Contractor may either route the call to another entity or conduct a "warm transfer" to another entity, but the Contractor shall not require an Enrollee to call a separate number regarding behavioral health services.

2.13.10.5 If the Contractor's nurse triage/nurse advice line is separate from its Enrollee services line, the number for the nurse triage/nurse advice line shall be the same for all Enrollees, regardless of whether they are calling about physical health or behavioral health services, and the Contractor may either route calls to another entity or conduct "warm transfers," but the Contractor shall not require an Enrollee to call a separate number.

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

2.13.10.7 The Contractor shall develop a contingency plan for hiring call center staff to address overflow calls and emails and to maintain call center access standards set forth for MCO performance. The Contractor shall develop and implement a plan to sustain call center performance levels in situations where there is high call and/or e-mail volume or low staff availability. Such situations may include, but are not limited to, increases in call volume, events described in the *Continuity of Operations Plan* section, staff participating in training, staff illnesses, and vacations.

2.13.10.8 The Contractor shall develop telephone help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards and emergencies including, but not limited to, hurricane-related evacuations. The Contractor shall submit these telephone help line policies and procedures, including performance standards, to LDH for written approval at least thirty (30) Calendar Days prior to implementation of any policies. This shall include a capability to track and report information on each call. The MCO call center shall have the capability to produce an electronic record to document a synopsis of all calls. The tracking shall include sufficient information to meet the reporting requirements.

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

2.13.10.10 The Contractor shall provide general assistance and information to individuals and their families seeking to understand how to access care. For CSoC eligible Enrollees, the Contractor shall provide information to families about the specialized services and how to contact the CSoC contractor.

2.13.11 24-Hour Behavioral Health Crisis Line

2.13.11.1 The Contractor shall maintain a twenty-four (24)-hour toll-free crisis response center to respond to specialized behavioral health needs. The call center may be combined with the Contractor's twenty-four (24)-hour nurse line or may be a separate line, but must:

2.13.11.1.1 Provide access to staff Twenty-four (24) hours a day, seven (7) days a week;

2.13.11.1.2 Answer with a live voice at all times within thirty (30) seconds;

2.13.11.1.3 Have sufficient telephone lines to answer incoming calls and meet performance standards set forth in this Contract;

2.13.11.1.4 Assist and triage callers who may be in crisis by effectuating an immediate transfer via a warm line to an LMHP for those who need a higher level of clinical skill, or a Recognized Peer Support Specialist (RPSS).

2.13.11.1.5 Be staffed with an adequate number of LMHPs overseeing clinical triage and other trained staff to handle to all calls received;

2.13.11.1.6 Coordinate connections to crisis mobile response team services closest to the Enrollee's location at the time of crisis;

2.13.11.1.7 Schedule outpatient follow-up appointments via a warm handoff to support connection to ongoing care following a crisis episode; and

2.13.11.1.8 Connect Enrollees to facility-based care through warm handoffs and coordination of transportation as needed.

2.13.11.2 During each call, behavioral health crisis line staff shall:

2.13.11.2.1 Try to resolve the crisis over the phone, and if needed will provide assistance in accessing face-to-face intervention, arranging an urgent outpatient appointment, providing phone consultation with an LMHP if a higher level of clinical skill is needed, or connecting the Enrollee with peer support services.

2.13.11.2.2 Engage individuals in a respectful and rapport-building manner providing assessment of risk of suicide for every call in a manner that meets National Suicide Prevention Lifeline standards and minimizes danger to others;

2.13.11.2.3 Initiate emergency response services when needed to secure the immediate safety of the Enrollee if the Enrollee is in need of medically necessary rescue services for an emergency medical need or when there is a concern for public safety;

2.13.11.2.4 Use call processing protocols (e.g., Robert's Model of Crisis Intervention), standardized risk assessments/instruments, and triage protocols to determine level of response for each call;

2.13.11.2.5 Use de-escalation and resolution techniques by engaging Enrollees in brief phone-based counseling and intervention to de-escalate the crisis with the goal of determining appropriate level of need and resolving the situation so that higher levels of care are not necessary;

2.13.11.2.6 Practice active engagement with persons calling on behalf of an Enrollee to determine the least invasive, most collaborative actions to best ensure the safety of the person at risk; and

2.13.11.2.7 Connect Enrollees to clinically appropriate additional care that uses the least invasive intervention and considers involuntary emergency interventions as a last resort.

2.13.11.3 The Contractor should use workforce management technology and tools to ensure adequate coverage of call volume and efficiencies and require internal monitoring of behavioral health crisis call processes. This can include coordinating overflow coverage with a resource that meets all 24-hour behavioral health crisis line expectations as outlined within the Louisiana Crisis Response Companion Guide when implemented.

2.13.11.4 In addition to standard call center reporting metrics, the Contractor shall report on 24-hour behavioral health crisis line specific functions, including, but not limited to, service level, call resolution, crisis mobile response team dispatch, and involvement of law enforcement or EMS, as specified by LDH.

2.13.11.5 For the 24-hour behavioral health crisis line, the Contractor shall incorporate Caller ID functionality in collaboration with partner crisis mobile response teams to more efficiently dispatch care to Enrollees in need.

2.13.11.6 The Contractor must have an after-hours system to route emergent and crisis behavioral health calls outside of its Enrollee services hours of operation in order to ensure Enrollees in crisis are able to access crisis services necessary to meet their needs.

2.13.12 Transportation Call Center

The Contractor or the Contractor's Transportation Broker shall establish and maintain a call center located in Louisiana. The call center shall be responsible for scheduling all NEMT reservations and dispatching of trips during the hours of 7:00 a.m. to 7:00 p.m. Central Time on Business Days.

2.13.13 Automated Call Distribution (ACD) System

The Contractor shall install, operate, and monitor a system for the customer service telephone call center. The system shall:

2.13.13.1 Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;

2.13.13.2 Transfer calls to other telephone lines;

2.13.13.3 Provide detailed analysis as required for the reporting requirements, as specified by LDH, including the quantity, length and types of calls received; elapsed time before the calls are answered; the number of calls transferred or referred; abandonment rate; wait time; busy rate; response time; and call volume;

2.13.13.4 Provide a message that notifies callers that the call may be monitored for quality control purposes;

2.13.13.5 Measure the number of calls in the queue;

2.13.13.6 Measure the length of time callers are on hold;

2.13.13.7 Measure the total number of calls and average calls handled per Business day/week/month;

2.13.13.8 Measure the average hours of use per Business day;

2.13.13.9 Assess the busiest times and days by number of calls;

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2.13.13.10 Record and play back inbound and outbound calls to assess whether answered accurately;

2.13.13.11 Provide a backup telephone system that shall operate in the event of line trouble, emergency situations including natural disasters, or other problems so that access to the telephone lines is not disrupted;

2.13.13.12 Provide interactive voice response (IVR) options that are user-friendly to Enrollees and include a decision tree illustrating IVR system; and

2.13.13.13 Inform the Enrollee to dial 911 if there is an emergency.

2.13.14 Call Center Performance Standards

The Contractor shall comply with the following call center performance standards. Unless otherwise specified in this Contract, these performance standards shall apply to all call centers required by this Contract.

2.13.14.1 The Contractor shall comply with the following requirements:

2.13.14.1.1 Answer ninety-five percent (95%) of calls within thirty (30) seconds or direct the calls to an automatic call pickup system with IVR options;

2.13.14.1.2 No more than one percent (1%) of incoming calls receive a busy signal;

2.13.14.1.3 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; and

2.13.14.1.4 Maintain abandoned rate of calls of not more than five percent (5%).

2.13.14.2 The Contractor shall conduct ongoing quality assurance to ensure these standards are met.

2.13.14.3 If LDH determines that it is necessary to conduct onsite monitoring of the Contractor's Enrollee call center functions, the Contractor is responsible for all reasonable costs incurred by LDH or its authorized agent(s) relating to such monitoring.

2.13.15 Interpretation and Written Translation Services

2.13.15.1 In accordance with 42 CFR §438.10(d) LDH shall provide on its website the prevalent non-English languages spoken by Enrollees in the State.

2.13.15.2 The Contractor shall make interpretation services, including real-time oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language (ASL), available free of charge to each Potential Enrollee and Enrollee. This applies to all non-English languages and not just those that Louisiana specifically requires (Spanish). These interpretation services shall be made available to Network Providers treating non-English speaking Enrollees at no charge. The Contractor may coordinate with the Louisiana Commission for the Deaf for American Sign Language interpretation services.

2.13.15.3 The Contractor shall notify its Enrollees that interpretation is available for any language and how to access those services. On materials where this information is provided, the notation shall be written in Spanish. Embedded videos in American Sign Language shall be made available on the MCO website with pertinent information labeled for Enrollees that are deaf, deaf-blind, or hard of hearing.

2.13.15.4 The Contractor shall ensure that translation services are provided for all written Marketing and Member Materials for any language that is spoken as a primary language for four percent (4%) or more Enrollees, or Potential Enrollees of an MCO. Within ninety (90) Calendar Days of notice from LDH, materials shall be translated and made available. Materials shall be made available at no charge in that specific language to ensure a reasonable chance for all Enrollees to understand how to access the MCO and use services appropriately as specified in 42 CFR §438.10(c)(4) and (5).

2.13.15.5 Written materials shall also be made available in alternative formats upon request of the Enrollee or Potential Enrollee at no cost. Written materials critical to obtaining services shall include taglines in the prevalent non-English languages in the State and large print explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and the toll-free and TTY/TDD telephone number of the Contractor's Enrollee customer service unit. Large print means printed in a conspicuously visible font size.

2.14 Marketing and Education

2.14.1 General Guidelines

2.14.1.1 Marketing, for purposes of this Contract, is defined in 42 CFR §438.104(a) as any communication from an MCO to a Beneficiary who is not enrolled in that MCO that can reasonably be interpreted to influence the Beneficiary to: 1) enroll in that MCO, or 2) either not enroll in, or disenroll from, another MCO.

2.14.1.2 Marketing differs from education, which is defined as communication with an **enrolled** member of an MCO for the purpose of retaining the Enrollee, and improving the health status of Enrollees.

2.14.1.3 Marketing and education includes both verbal presentations and written materials.

2.14.1.4 Marketing Materials are produced in any medium and include, but are not limited to, the concepts of advertising, public service announcements, printed publications, websites, social media, mobile device applications, broadcasts and electronic messages designed to increase awareness and interest in the MCO. This includes any information that can reasonably be interpreted as intended to market the MCO to Potential Enrollees.

2.14.1.5 Member Materials generally include, but are not limited to, Member Handbooks, MCO Member ID cards, Provider Directories, health education materials, form letters, mass mailings, e-mails, SMS messages, Enrollee letters, and newsletters.

2.14.1.6 All Marketing and education guidelines are applicable to the Contractor, its agents, Subcontractors, volunteers, and/or Network Providers.

2.14.1.7 All Marketing and education activities shall be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of Beneficiaries or the general community.

2.14.1.8 The Contractor shall provide information to Enrollees and Potential Enrollees in a manner and format that may be easily understood and is

readily accessible by such Enrollees and Potential Enrollees [42 CFR §438.10(c)(1)]. All Marketing and Member Materials and activities shall comply with the information requirements in 42 CFR §438.10 and the LDH requirements set forth in this Contract, the **MCO Manual,** and the **Marketing and Member Education Companion Guide**.

2.14.1.9 The Contractor shall make its written materials that are critical to obtaining services, including provider directories, Member Handbooks, Appeal and Grievance notices, and denial and termination notices available in the prevalent non-English languages in the State as required by LDH [42 CFR §438.10(d)(3)]. The Contractor is responsible for creation, production and distribution of its own Marketing and Member Materials to its Enrollees.

2.14.1.10 The Contractor shall not perform any direct Marketing to Potential Enrollees in accordance with 42 U.S.C. §1396u-2(d)(2) and 42 CFR §438.104.

2.14.1.11 Activities involving distribution and completion of an MCO Enrollment form during the course of Enrollment activities is an Enrollment function and is the sole responsibility of LDH's Enrollment Broker.

2.14.1.12 The Contractor shall ensure that Marketing and Member Materials are accurate and do not mislead, confuse, or defraud the Enrollee/Potential Enrollee or LDH as required by 42 U.S.C. §1396u-2(d)(2) and 42 CFR §438.104.

2.14.1.13 The Contractor shall comply with the National Standards for Culturally and Linguistically Appropriate Services in health and health care, as outlined by the Department of Health and Human Services' Office of Minority Health, incorporating the standards found here: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53. Additionally, the Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all Enrollees.

2.14.1.14 The Contractor shall develop Marketing and Member Materials that appropriately address all the MCO populations outlined in the *Eligibility and Enrollment* section of the Contract.

2.14.1.15 Sponsorships or grants and events shall be scheduled throughout the State in a geographically equitable manner.

2.14.2 Prohibited Marketing Activities

The Contractor and its Subcontractors are prohibited from engaging in the following activities:

2.14.2.1 Marketing directly or indirectly to Beneficiaries, including persons currently enrolled in FFS or other MCOs (including direct mail advertising, "spam", door-to-door, telephonic, e-mail, texting, or other "cold call" Marketing techniques);

2.14.2.2 Asserting that the Contractor is endorsed by CMS, the Federal or State government or similar entity;

2.14.2.3 Distributing plans and materials or making any statement (written or verbal) that LDH determines to be inaccurate, false, confusing, misleading or intended to defraud Enrollees or LDH. This includes statements which mislead or falsely describe MCO Covered Services, membership or availability of providers and qualifications and skills of providers, and assertions the recipient of the communication must enroll in a specific plan in order to obtain or not lose benefits;

2.14.2.4 Portraying competitors or potential competitors in a negative manner;

2.14.2.5 Attaching a Louisiana Medicaid Program application and/or Enrollment form to Marketing Materials distributed to any Enrollee not currently enrolled with the Contractor;

2.14.2.6 Assisting with Enrollment or Disenrollment or improperly influencing MCO selection;

2.14.2.7 Using the seal of the State, LDH's name, logo or other identifying marks on any materials produced or issued, without the prior written consent of LDH;

2.14.2.8 Distributing Marketing information (written or verbal) that implies that joining MCOs or a particular MCO is the only means of preserving Louisiana Medicaid Program coverage or that MCOs or a particular MCO is the only provider of Medicaid Covered Services and that the Potential Enrollee must enroll in the MCO or MCOs to obtain benefits or not lose benefits;

2.14.2.9 Comparing its MCO to another organization / MCO by name;

2.14.2.10 Sponsoring or attending any Marketing or community health activities or events without notifying LDH in writing within the timeframes specified in this Contract;

2.14.2.11 Engaging in any Marketing activities, including unsolicited personal contact with a Potential Enrollee, at an employer-sponsored enrollment event where employee participation is mandated by the employer;

2.14.2.12 Marketing or distributing Marketing Materials, including Member Handbooks, and soliciting Enrollees in any other manner, inside, at the entrance or within one hundred (100) feet of Louisiana Medicaid Program

Deleted: check cashing establishments, public assistance offices, DCFS eligibility offices for the Supplemental Nutrition Assistance Program (SNAP), FITAP, Health Units,

Eligibility Offices, and/or certified Medicaid Application Centers without prior approval from LDH;

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2.14.2.13 Conducting Marketing or distributing Marketing Materials in EDs, including the ED waiting areas, patient rooms or treatment areas;

2.14.2.14 Purchasing or otherwise acquiring or using mailing lists of Beneficiaries from third party vendors, including providers and State offices;

2.14.2.15 Using raffle tickets or event attendance or sign-in sheets to develop mailing lists of Potential Enrollees;

2.14.2.16 Charging Enrollees for goods or services distributed at events;

2.14.2.17 Charging Enrollees a fee for accessing the Contractor's website;

2.14.2.18 Influencing Enrollment in conjunction with the sale or offering of any private insurance or Medicare Advantage Plan;

2.14.2.19 Using terms that would influence, mislead, or cause Beneficiaries to contact the Contractor, rather than the Enrollment Broker, for Enrollment; and

2.14.2.20 Using terms in Marketing Materials such as "choose," "pick," "join," etc. unless the Marketing Materials include the Enrollment Broker's contact and mobile application information.

2.14.3 Allowable Marketing Activities

2.14.3.1 The Contractor and its Subcontractors shall be permitted to perform the following activities:

2.14.3.1.1 Distribute general information through mass media (i.e. newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, billboards and other media outlets) in keeping with prohibitions to placement as detailed in this Contract;

2.14.3.1.2 Make telephone calls and home visits only to Enrollees currently enrolled in the MCO (member education and outreach) for the purpose of educating them about services offered by or available through the MCO;

2.14.3.1.3 Respond to verbal or written requests for information made by Potential Enrollees, in compliance with the response plan outlined in the Marketing and Member Education Plan (see **MCO Manual**), approved by LDH in writing prior to response;

2.14.3.1.4 Provide promotional giveaways that exceed fifteen dollar ($15.00) value to current Enrollees only;

2.14.3.1.5 Attend or organize activities that benefit the entire community, such as health fairs or other health education and promotion activities. Notification to LDH must be made of the activity and details must be provided about the planned Marketing activities;

2.14.3.1.6 Attend activities at a business at the invitation of the entity. Notification to LDH shall be made of the activity and details shall be provided about the planned Marketing activities;

2.14.3.1.7 Conduct telephone Marketing only during incoming calls from Potential Enrollees. The Contractor may return telephone calls to Potential Enrollees only when requested to do so by the caller. The Contractor shall utilize the response plan outlined in the **Marketing and Member Education Companion Guide**, approved by LDH in writing, during these calls; and

2.14.3.1.8 Send Contractor-specific materials to Potential Enrollees at the Potential Enrollee's request.

2.14.3.2 In any instance where an allowable activity conflicts with a prohibited activity, the prohibited activity guidance shall prevail.

2.14.4 Marketing and Member Materials Approval Process

2.14.4.1 The Contractor shall obtain prior written approval from LDH for all Marketing and Member Materials for Potential or current Enrollees. This includes, but is not limited to, print, television, web, and radio advertisements; Member Handbooks, MCO Member ID Cards and Provider Directories; call scripts for outbound calls or customer service centers; MCO website screen shots; promotional items; brochures; letters and mass mailings and e-mailings. Neither the Contractor nor its Subcontractors may distribute any Marketing or Member Materials without prior LDH consent.

2.14.4.2 All proposed materials shall be submitted via email to LDH in a format and manner approved by LDH in writing.

2.14.4.2.1 Materials submitted as part of the original Marketing and Member Education Plan shall be considered approved with the approval of the plan if the materials were in final draft form.

2.14.4.3 The Contractor shall obtain prior written approval by LDH for all materials developed by a recognized entity that is not associated with the Contractor, such as a government entity or a nonprofit organization, that the Contractor wishes to distribute. LDH shall only consider materials when submitted by the Contractor (not Subcontractors).

2.14.4.4 Review Process for Materials

2.14.4.4.1 LDH shall review the submitted Marketing and Member Materials and either approve, deny or submit changes in writing within thirty (30) Calendar Days from the date of submission.

2.14.4.4.2 Once Member Materials are approved in writing by LDH, the Contractor shall submit to LDH an electronic version of the final printed product within ten (10) Calendar Days from the print date, unless otherwise specified by LDH. If LDH requests that original prints be submitted in

hard copy, photocopies may not be submitted for the final product. Upon request, the Contractor shall provide additional original prints of the final product to LDH.

2.14.4.4.3 Prior to modifying any approved Member Material, the Contractor shall submit for written approval by LDH, a detailed description of the proposed modification accompanied by a draft of the proposed modification.

2.14.4.4.4 LDH reserves the right to require the Contractor to discontinue or modify any Marketing or Member Materials after approval.

2.14.4.4.5 Contractor materials used for the purpose of Marketing and education, except for the original Marketing and Member Education Plan, are deemed approved if a response from LDH is not returned within thirty (30) Calendar Days following receipt of materials by LDH.

2.14.4.4.6 The Contractor shall review all Marketing and Member Materials on an annual basis and revise materials, if necessary, to reflect current practices. Any revisions shall be approved by LDH in writing prior to distribution.

2.14.5 Events and Activities Approval Process

2.14.5.1 The Contractor shall provide written notice to LDH in accordance with the **Marketing and Member Education Companion Guide** for all Marketing and member education events and activities for potential or current Enrollees as well as any community/health education activities that are focused on health care benefits (health fairs or other health education and promotion activities).

2.14.5.2 The Contractor shall obtain prior written approval from LDH for any press or media events or activities or activities that it is sponsoring.

2.14.5.2.1 Activities and events submitted as part of the original Marketing and member education plan shall be considered approved with the approval of the plan if the activity or event details are complete.

2.14.5.2.2 The Contractor's sponsorship or grant distribution must be equitable across all nine (9) Louisiana Medicaid Program geographic regions. Equitability is assessed through a comparison of sponsorship or grant dollars to total Enrollees within a specific region. If a sponsorship or grant is not within the equitability range, LDH may deny approval.

2.14.5.2.3 To consider denial of approval based on equitability, the following criteria must all be present:

2.14.5.2.3.1 Contractor has sponsored at least one percent (1%) of statewide sponsorships or grants;

2.14.5.2.3.2 Contractor is over equity range for the region in question;

2.14.5.2.3.3 Contractor is under equity range in at least one region;

2.14.5.2.3.4 Aggregated MCOs are over equity range for the region in question; and

2.14.5.2.3.5 There has been no major disaster declaration active in the past six (6) months.

2.14.5.3 Review Process for Events and Activities

2.14.5.3.1 LDH shall review proposed sponsorships, grants, press, or media events and activities and either approve or deny in writing within seven (7) Calendar Days from the date of submission.

2.14.5.3.2 In the case where a sponsorship, grant, press, or media event or activity arises and approval within the seven (7) Calendar Day timeframe is not possible due to the proximity of the event or activity, the Contractor may request an expedited approval in writing. LDH reserves the right to deny such requests.

2.14.5.3.3 Proposed sponsorships, grants, press, or media events and activities, except for those included in the original Marketing and member education plan, are deemed approved if a response from LDH is not returned within seven (7) Calendar Days following notice of event to LDH.

2.14.5.3.4 Any revisions to approved sponsorships, grants, press, or media events and activities must be resubmitted for approval by LDH in writing prior to the event or activity in accordance with the **Marketing and Member Education Companion Guide**.

2.14.5.3.5 LDH reserves the right to require the Contractor to discontinue or modify any Marketing or member education events after approval by LDH in writing.

2.14.6 MCO Provider Marketing

2.14.6.1 When conducting any form of Marketing in a provider's office, the Contractor shall acquire and keep on file the written consent of the provider.

2.14.6.2 The Contractor shall not require its Network Providers to distribute Contractor-prepared Marketing communications to their patients.

2.14.6.3 The Contractor shall not provide incentives or giveaways to providers to distribute Marketing communications to Enrollees or Potential Enrollees.

2.14.6.4 The Contractor shall not conduct member education or distribute member education materials in provider offices, with the exception of health education materials (branded or non-branded) with the provider's consent.

2.14.6.5 The Contractor shall not allow Network Providers to solicit Enrollment or Disenrollment in an MCO, or distribute Contractor-specific materials as a Marketing activity.

2.14.6.6 The Contractor shall not provide printed materials with instructions detailing how to change MCOs to Enrollees of other MCOs to providers.

2.14.6.7 The Contractor shall instruct Network Providers regarding the following communication requirements:

2.14.6.7.1 Network Providers who wish to let their patients know of their affiliations with one (1) or more MCOs shall list each MCO with whom they have contracts;

2.14.6.7.2 Network Providers may display and/or distribute health education materials for **all** contracted MCOs or they may choose not to display and/or distribute for **any** contracted MCOs. Health education materials shall adhere to the following guidance:

2.14.6.7.2.1 Health education posters cannot be larger than 16" x 24";

2.14.6.7.2.2 Children's books, donated by MCOs, must be in common areas;

2.14.6.7.2.3 Materials may include the MCO's name, logo, phone number and website; and

2.14.6.7.2.4 Providers are not required to distribute and/or display all health education materials provided by each MCO with whom they contract. Providers can choose which items to display as long as they distribute items from each contracted MCO and that the distribution and quantity of items displayed are equitable;

2.14.6.7.3 Providers may display Marketing Materials for MCOs provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all MCOs with whom the provider has a contract;

2.14.6.7.4 Providers may display MCO participation stickers, but they shall display stickers by **all** contracted MCOs or choose to not display stickers for **any** contracted MCOs;

2.14.6.7.5 MCO stickers indicating the provider participates with a particular MCO cannot be larger than 5" x 7" and may not include anything more than the MCO name and/or logo or with the statement that it is accepted or welcomed here;

2.14.6.7.6 Providers may inform their patients of the benefits, services and specialty care services offered through the MCOs in which they participate. However, providers shall not recommend one MCO over another MCO, offer patients incentives for selecting one MCO over another, assist the patient in deciding to select a specific MCO in any way, or otherwise intend to influence an Enrollee's decision; and

2.14.6.7.7 The Contractor shall not produce branded materials instructing Enrollees on how to change a MCO. They must use LDH provided or approved materials and shall refer Enrollees directly to the Enrollment Broker for needed assistance.

2.14.7 MCO Marketing Representatives

2.14.7.1 All Marketing representatives, including Subcontractors assigned to Marketing, shall successfully complete a training program about the basic concepts of the Louisiana Medicaid Program, the Managed Care Program, and the Enrollees' rights and responsibilities relating to Enrollment in MCOs and Grievance and Appeals rights before engaging in direct Marketing to Potential Enrollees.

2.14.7.2 The Contractor shall ensure that all Marketing representatives engage in professional and courteous behavior. The Contractor shall not participate, encourage, or accept inappropriate behavior by its Marketing representatives, including, but not limited to, interference with presentations by other MCOs or talking negatively about other MCOs.

2.14.7.3 The Contractor shall not offer compensation to a Marketing representative, including salary increases or bonuses, based solely on an overall increase in Enrollment. Compensation may be based on periodic performance evaluations which consider Enrollment productivity as one (1) of several performance factors.

2.14.7.4 Sign-on bonuses for Marketing representatives are prohibited.

2.14.8 Written Materials

The Contractor shall comply with the following requirements as it relates to all written Member Materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.). The Contractor shall also comply with the requirements outlined in 42 CFR §438.10, 42 U.S.C. §1396u-2(d)(2)(A)(i), and 42 U.S.C. §1396u-2(a)(5):

2.14.8.1 All Member Materials shall be in a style and reading level that shall accommodate the reading skills of the Contractor's Enrollees. In general, the writing shall be at no higher than a 6.9 grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to ensure accuracy:

- Flesch – Kincaid;
- Fry Readability Index;
- PROSE The Readability Analyst (software developed by Educational Activities, Inc.);
- Gunning FOG Index;
- McLaughlin SMOG Index; or
- Other computer generated readability indices accepted by LDH.
- All written materials shall be clearly legible with a minimum font size of twelve (12)-point, with the exception of MCO Member ID Cards, and or otherwise approved by LDH in writing.

2.14.8.2 LDH reserves the right to require evidence that written materials for Enrollees have been tested against the 6.9 grade reading-level standard.

2.14.8.3 If a person making a testimonial or endorsement for the Contractor has a financial interest in the company, such fact shall be disclosed in the Marketing Materials.

2.14.8.4 The quality of materials used for printed materials shall be, at a minimum, equal to the materials used for printed materials for the Contractor's commercial plans if applicable.

2.14.8.5 The MCO's name, mailing address (and physical location, if different), website and toll-free number shall be prominently displayed on at least one (1) page within all multi-paged Marketing Materials.

2.14.8.6 All multi-page written Member Materials shall notify the Enrollee that real-time oral and American Sign Language interpretation is available for any language at no expense to them and provide information on how to access those services;

2.14.8.7 All written materials related to MCO and PCP Enrollment shall advise Potential Enrollees to verify with the medical services providers they prefer or have an existing relationship with, that such medical services providers are Network Providers of the selected MCO and are available to serve the Enrollee.

2.14.8.8 Alternative forms of communication shall be provided upon request for persons with visual, hearing, speech, physical or developmental disabilities. These alternatives shall be provided at no expense to the Enrollee.

2.14.8.9 Marketing materials shall be made available through the Contractor's entire service area. Materials may be customized for specific parishes and populations within the Contractor's service area.

2.14.8.10 All Marketing activities shall provide for equitable distribution of materials without bias toward or against any group.

2.14.8.11 Marketing materials shall accurately reflect general information, which is applicable to the average Potential Enrollee of the Contractor.

2.14.8.12 The Contractor shall include the following information in all Member Materials:

2.14.8.12.1 The date of issue;

2.14.8.12.2 The date of revision; and/or

2.14.8.12.3 If the prior versions are obsolete.

2.14.8.13 Except as otherwise indicated in the **Marketing and Member Education Companion Guide**, the MCOs may develop their own materials that

adhere to requirements set forth in this Contract or use State developed model Enrollee notices. State developed model notices must be used for denial notices and pharmacy lock-in notices.

2.14.9 Website

2.14.9.1 The Contractor's website, available in English and Spanish, shall include an Enrollee-focused section which can be a designated section of the Contractor's general informational website, which is interactive and accessible using mobile devices, and has the capability for bidirectional communications, i.e. Enrollees can submit questions and comments to the Contractor and receive responses.

2.14.9.2 The website shall include general and up-to-date information about the Contractor as it relates to the Managed Care Program. This may be developed on a page within its existing website to meet these requirements.

2.14.9.3 The Contractor shall obtain prior written approval from LDH before updating the Enrollee-facing portion of its website, unless the new content has been approved in writing in another format.

2.14.9.4 The Contractor shall remain compliant with the HIPAA Privacy and Security Rules when providing Enrollee eligibility or Enrollee identification information on the website.

2.14.9.5 The Contractor's website shall, at a minimum, comply with Section 508 of the ADA, and meet all standards the ADA sets for people with visual impairments and disabilities that make usability a concern. The Contractor's website shall follow all written Marketing guidelines included in this Section.

2.14.9.6 Use of proprietary items that would require a specific browser is not allowed.

2.14.9.7 The Contractor shall provide the following information on its website, and such information shall be easy to find, navigate, and understand by all Enrollees:

2.14.9.7.1 The most recent version of the Member Handbook;

2.14.9.7.2 Telephone contact information, including a toll-free customer service number prominently displayed and a Telecommunications Device for the Deaf (TDD) number;

2.14.9.7.3 A searchable list of Network Providers with a designation of open versus closed panels, which shall be updated in real time and upon changes to the network;

2.14.9.7.4 The link to the Enrollment Broker's website, mobile application, and toll-free number for questions about Enrollment and Disenrollment;

2.14.9.7.5 The link to the Louisiana Medicaid Program website and the toll-free number for questions about Louisiana Medicaid Program eligibility;

2.14.9.7.6 General customer service information;

2.14.9.7.7 Updates on emergency situations that may impact the public, such as the events described in the *Continuity of Operations Plan* section, that would require time sensitive action by Enrollees, such as evacuation from their homes or communities or other preparedness-related activities. The website shall include hyperlinks to State and Federal emergency preparedness websites;

2.14.9.7.8 Information on how to file Grievances and Appeals; and

2.14.9.7.9 Information specific to access for SBHS, including, but not limited to:

2.14.9.7.9.1 The link to the LDH-OBH and CSoC websites;

2.14.9.7.9.2 Information on how to access SBHS, including crisis response services implemented through the Louisiana Crisis Response System;

2.14.9.7.9.3 Crisis response information and toll-free crisis telephone numbers;

2.14.9.7.9.4 Information regarding community forums, volunteer activities, and workgroups/committees that provide opportunities for Enrollees receiving services, their families/caregivers, providers, and stakeholders to become involved; and

2.14.9.7.9.5 Information regarding advocacy organizations, including how Enrollees and other families/caregivers may access advocacy services.

2.14.10 Web and Mobile-Based Enrollee Applications

2.14.10.1 No later than the Operational Start Date, the Contractor shall provide a web or mobile based Enrollee/patient portal that includes the following information and features:

2.14.10.1.1 Medical Claims information such as lab and imaging results, medications and key health appointments;

2.14.10.1.2 Social services information and resources, such as housing supports, food programs, etc.;

2.14.10.1.3 The capability for additional health information to be entered by the Enrollee;

2.14.10.1.4 Consumer-friendly content that complies with MCO education guidelines; and

2.14.10.1.5 Tools to help higher risk users access State-based or plan-based resources such as smoking cessation or weight management programs. Need will be determined by the MCO health-risk assessment or other tools used for establishing higher risk users.

2.14.10.2 The Contractor shall develop and promote patient engagement tools, including mobile applications and smartphone-based support to supplement existing pregnancy services. The Contractor shall provide details of its plan in the MCO Marketing and Outreach Plan submitted to LDH for written approval.

2.14.10.3 The Contractor shall provide reporting and analytics to help the State measure the effectiveness of such applications.

2.14.11 Marketing Reporting and Monitoring

2.14.11.1 The Contractor shall submit an updated plan of all anticipated Marketing and member education efforts for the coming year to LDH in accordance with the **Marketing and Member Education Companion Guide**.

2.14.11.2 To ensure the fair and consistent investigation of alleged violations, LDH has outlined the following reporting guidelines:

2.14.11.2.1 The Contractor shall report alleged Marketing violations to LDH in accordance with the **Marketing and Member Education Companion Guide**.

2.14.11.2.2 Upon written receipt of allegations, LDH shall:

2.14.11.2.2.1 Acknowledge receipt, in writing, within five (5) Business Days from the date of receipt of the allegation.

2.14.11.2.2.2 Begin investigation within five (5) Business Days from receipt of the allegation and complete the investigation within thirty (30) Calendar Days. LDH may extend the time for investigation if there are extenuating circumstances;

2.14.11.2.2.3 Analyze the findings and take appropriate action (see *Contract Non-Compliance* section, for additional details); and

2.14.11.2.2.4 Notify the complainant after appropriate action has been taken.

2.14.11.3 LDH may impose sanctions against the Contractor for Marketing and member education violations as outlined in the *Contract Non-Compliance* section of this Contract.

2.14.12 Pharmacy-Related Marketing and Member Education

2.14.12.1 The Contractor, its Subcontractors, including PBMs, and Network Providers, are subject to the Marketing and member education requirements set forth in this section. This includes the review and written approval of all Marketing and Member Materials including, but not limited to, websites and social media, Pharmacy ID Cards, call scripts for outbound calls or customer service centers, provider directories, advertisement and direct Enrollee mailings.

2.14.12.2 The Contractor's Enrollees shall have free access to any pharmacy participating in the Contractor's network (except in cases where the Enrollee is participating in the pharmacy/prescriber lock-in program). Neither the Contractor nor any Subcontractor is allowed to steer Enrollees to certain Network Providers including specialty pharmacies. LDH retains the discretion to deny the use of Marketing and Member Material that it deems to promote undue patient steering, including, but not limited to, Enrollee web portals and mobile-based Enrollee applications.

2.14.12.3 The Contractor is prohibited from displaying the names and/or logos of co-branded PBMs on the MCO Member ID Card. Co-branded Marketing Materials that display the names and/or logos of co-branded PBMs must include the following language: "Other Pharmacies are Available in Our Network."

2.14.12.4 Co-branded Marketing Materials shall be submitted to LDH by the Contractor for approval in writing prior to distribution, in accordance with the processes and timelines outlined in this section.

2.14.13 Marketing and Education Violations

2.14.13.1 Whenever LDH determines that the Contractor or any of its agents, Subcontractors, volunteers or providers has engaged in any unfair, deceptive, or prohibited Marketing or member education practices in connection with proposing, offering, selling, soliciting, and providing any health care services, one or more of the remedial actions as specified in this Section shall apply.

2.14.13.2 Unfair, deceptive, or prohibited Marketing and member education practices shall include, but are not limited to:

2.14.13.2.1 Failure to secure written approval before distributing Marketing or Member Materials;

2.14.13.2.2 Failure to secure written approval for events involving sponsorships or grants and media events;

2.14.13.2.3 Engaging in, encouraging, or facilitating prohibited Marketing by a provider;

2.14.13.2.4 Directly Marketing to Enrollees of another MCO or Potential Enrollees;

2.14.13.2.5 Failure to meet time requirements for communication with new Enrollees (distribution of welcome packets, welcome calls);

2.14.13.2.6 Failure to provide interpretation services or make materials available in required languages;

2.14.13.2.7 Engaging in any of the prohibited Marketing and member education practices detailed in this Contract;

2.14.13.2.8 Utilization of a false, misleading oral or written statement, visual description, advertisement, or other representation of any kind which has the capacity, tendency, or effect of deceiving or misleading Potential Enrollees or Enrollees with respect to any health care services, MCO, or health care provider; or the Managed Care Program;

2.14.13.2.9 Representation that the Contractor or Network Provider offers any service, benefit, access to care, or choice which it does not have;

2.14.13.2.10 Representation that the Contractor or health care provider has any status, certification, qualification, sponsorship, grant, affiliation, or licensure which it does not have;

2.14.13.2.11 Failure to state a material fact if the failure deceives or tends to deceive;

2.14.13.2.12 Offering any kickback, bribe, award, or benefit to any Beneficiary as an inducement to select, or to refrain from selecting any health care service, MCO, or health care provider, unless the benefit offered is medically necessary health care or is among the Value-Added Benefits that are offered to all Enrollees or predefined eligibility groups; and

2.14.13.2.13 Use of the Beneficiary's or another person's information which is confidential, privileged, or which cannot be disclosed to or obtained by the user without violating a State or Federal confidentiality law, including:

2.14.13.2.13.1 Medical records information;

2.14.13.2.13.2 Information that identifies the Enrollee or any member of his or her household as a participant of any government sponsored or mandated health coverage program; and

2.14.13.2.13.3 Use of any device or artifice in advertising the Contractor or soliciting a Beneficiary which misrepresents the solicitor's profession, status, affiliation, or mission.

2.14.13.3 The Contractor shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.

2.14.13.4 If LDH determines the Contractor or its Subcontractors has steered Potential Enrollees to join the Contractor, LDH may impose one or more of the following non-compliance actions:

2.14.13.4.1 The Enrollee(s) shall be disenrolled from the Contractor at the earliest effective date allowed;

2.14.13.4.2 PMPMs for the months(s) the Enrollee(s) was enrolled in the Contractor will be recouped;

2.14.13.4.3 The Contractor shall be assessed an additional Monetary Penalty per Enrollee (see Attachment G, *Table of Monetary Penalties*); and/or

2.14.13.4.4 The Contractor shall submit a letter to each Enrollee notifying the Enrollee of the imposed sanction and of their right to choose another MCO.

2.14.13.5 If LDH determines the Contractor has violated any of the Marketing or education activities outlined in the Contract, the Contractor may be subject to remedial actions specified in this Section and/or a Monetary Penalty per violation/incident (see Attachment G, *Table of Monetary Penalties*). The type of penalty shall be at the sole discretion of LDH.

2.14.14 Remedial Actions for Marketing Violations

2.14.14.1 LDH shall notify the Contractor in writing of the determination of non-compliance, of the remedial action(s) that must be taken, and of any other related conditions such as the length of time the remedial actions shall continue and the corrective actions that the Contractor shall perform.

2.14.14.2 LDH may require the Contractor to recall previously authorized Marketing Material(s).

2.14.14.3 LDH may suspend Enrollment of new Enrollees to the Contractor for an amount of time specified by LDH.

2.14.14.4 LDH may require the Contractor to contact, in a manner specified by LDH, each Enrollee who enrolled during the period while the Contractor was out of compliance, in order to explain the nature of the non-compliance and inform the Enrollee of his or her right to transfer to another MCO.

2.14.14.5 LDH may prohibit future Marketing activities by the Contractor for an amount of time specified by LDH.

2.15 Enrollee Grievances, Appeals, and State Fair Hearings

2.15.1 General Provisions

2.15.1.1 The Contractor shall establish and maintain a system for receiving, reviewing, and resolving Enrollee Grievances and Appeals. Components shall include a Grievance process, an Appeal Procedure, and a process to access a State Fair Hearing.

2.15.1.2 The Contractor shall ensure that all Enrollees are informed of all the processes. Forms with which Enrollees may file Grievances or Appeals shall be available through the Contractor, and shall be provided upon request of the Enrollee. The Contractor shall make all forms readily accessible on the Contractor's website.

2.15.1.3 The Contractor shall ensure that all decisions on Grievances and Appeals are made by health care professionals in accordance with Federal regulations.

2.15.1.4 The Contractor shall refer all Enrollees who are dissatisfied with the Contractor or its activities to the Contractor's Grievance system.

2.15.1.5 The Contractor shall assist the Enrollee in completing forms and following the procedures for filing a Grievance or Appeal or requesting a State Fair Hearing.

2.15.1.6 Upon request, the Contractor shall provide the Enrollee and his or her Authorized Representative the Enrollee's record, including all medical records and any other documents and records considered or relied upon by the Contractor regarding an Appeal or State Fair Hearing, including the opportunity before and during the Appeal or State Fair Hearing process for the Enrollee or an Authorized Representative to examine the record. The Contractor shall provide such records free of charge and within seven (7) Calendar Days of receipt of the request.

2.15.1.7 The Contractor and its Subcontractors shall maintain a complete and accurate record of all Grievances and Appeals for a period of no less than ten (10) years following termination of the Contract. The Contractor shall make Grievance and Appeal records available upon request by LDH and CMS. The record of each Grievance and Appeal shall contain, at a minimum, the information specified in 42 CFR §438.416(b).

2.15.1.8 The Contractor shall log, track, and trend all Grievances, regardless of the degree of seriousness or whether the Enrollee expressly requests filing the concern.

2.15.1.9 The Contractor shall report on Grievances and Appeals to LDH in a manner and format determined by LDH.

2.15.1.10 The Contractor shall dispose of a Grievance and resolve each Appeal, and provide notice, as expeditiously as the Enrollee's health condition requires, within the timeframes established herein.

2.15.1.11 A provider may file an Appeal or request a State Fair Hearing on behalf of the Enrollee with the Enrollee's written consent. The Enrollee's consent shall not be required for provider Appeals of Claim denials.

2.15.2 Process for Grievances

2.15.2.1 An Enrollee, or Authorized Representative acting on the Enrollee's behalf, may file a Grievance orally or in writing at any time.

2.15.2.2 The Contractor's process for handling Enrollee Grievances shall include acknowledgement in writing within five (5) Business Days of receipt of each Grievance.

2.15.2.3 The Contractor shall review the Grievance and provide written notice to the Enrollee of the disposition of a Grievance no later than ninety (90) Calendar Days from the date the Contractor receives the Grievance.

2.15.2.4 2.15.2.4 The Contractor may extend the timeframe for disposition of a Grievance by up to fourteen (14) Calendar Days if:

2.15.2.4.1 The Enrollee requests the extension; or

2.15.2.4.2 The Contractor shows (to the satisfaction of LDH, upon its request) that there is a need for additional information and how the delay is in the best interest of the Enrollee.

2.15.2.5 If the timeframe is extended other than at the Enrollee's request, the Contractor shall complete all of the following:

2.15.2.5.1 Provide oral notice of the extension to the Enrollee by close of business on the day the Contractor decides to extend the timeframe;

2.15.2.5.2 Provide written notice of the reason for the extension within two (2) Calendar Days after the Contractor decides to extend the timeframe. The written notice shall also inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and

2.15.2.5.3 Resolve the Grievance as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

2.15.3 Process for Appeals

2.15.3.1 Submission and Processing of Appeals

2.15.3.1.1 An Enrollee, Authorized Representative, or legal representative may file an Appeal with the Contractor, orally or in writing, within sixty (60) Calendar Days from the date on the notice of Adverse Benefit Determination.

2.15.3.1.2 Once an oral Appeal is received, the Contractor shall inform the Enrollee they shall receive a notice or written confirmation of the Appeal. The date of the oral filing shall constitute date of receipt.

2.15.3.1.3 The Contractor shall acknowledge each Appeal in writing within five (5) Business Days of receipt of each Appeal unless the Enrollee requests an expedited resolution.

2.15.3.1.4 The Contractor shall provide the Enrollee a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing.

2.15.3.1.5 The Contractor shall provide the Enrollee, the Enrollee's Authorized Representative, and the Enrollee's legal representative opportunity, before and during the Appeals process, to examine the Enrollee's case file, including medical records and any other documents and records considered during the Appeals process.

2.15.3.1.6 The Contractor shall include as parties to the Appeal:

2.15.3.1.6.1 The Enrollee, the Enrollee's Authorized Representative, and/or the Enrollee's legal representative; or

2.15.3.1.6.2 The legal representative of a deceased Enrollee's estate.

2.15.3.2 Continuation of Benefits

2.15.3.2.1 The Contractor shall continue to provide benefits and services during the Appeal if all of the following occur:

2.15.3.2.1.1 The for an Appeal is filed Timely as defined in the Contract in accordance with applicable Federal and State laws, regulations, rules, policies, procedures, and manual. As used in this section, "Timely"' filing means filing on or before the later of the following:

Within ten (10) Calendar Days of the Contractor mailing the notice of Adverse Benefit Determination; or

The intended effective date of the Contractor's proposed action.

2.15.3.2.1.2 The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

2.15.3.2.1.3 The services were ordered by an authorized provider;

2.15.3.2.1.4 The original period covered by the original authorization has not expired; and

2.15.3.2.1.5 The Enrollee Timely files for continuation of benefits.

2.15.3.2.2 If, at the Enrollee's request, the Contractor continues or reinstates the Enrollee's benefits while the Appeal is pending, the benefits shall be continued until one of following occurs:

2.15.3.2.2.1 The Enrollee withdraws the Appeal;

2.15.3.2.2.2 Ten (10) Calendar Days pass after the Contractor mails the notice providing the resolution of the Appeal adverse to the Enrollee, unless the Enrollee, within the ten (10) Calendar Day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached;

2.15.3.2.2.3 Following a State Fair Hearing, the administrative law judge issues a hearing decision adverse to the Enrollee; or

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

2.15.3.3 Standard Resolution of Appeals

2.15.3.3.1 For resolution, an Appeal shall be heard and notice of Appeal resolution shall be sent to the Enrollee and all parties no later than thirty (30) Calendar Days from the date the Contractor receives the Appeal.

2.15.3.3.2 If a determination is not made in accordance with the timeframe specified, the Enrollee's request shall be deemed to have exhausted the Contractor's Appeal Procedure as of the date

upon which a final determination should have been made. The Enrollee may then initiate a State Fair Hearing.

2.15.3.4 Expedited Resolution of Appeals

2.15.3.4.1 The Contractor shall establish and maintain an expedited review process for Appeals, when the Contractor determines (for Enrollee requests) or indicates (when requesting on the Enrollee's behalf or supporting the Enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function.

2.15.3.4.2 The Contractor shall resolve each expedited Appeal and provide notice to the Enrollee, as quickly as the Enrollee's health condition requires, within established timeframes not to exceed seventy-two (72) hours after the Contractor receives the Appeal request, whether the Appeal was made orally or in writing.

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

2.15.3.4.4 If an Enrollee asks for an extension, the Contractor shall treat the request as a denial for expedited Appeal, immediately transfer the Appeal to the timeframe for standard resolution, and shall so notify the Enrollee. Nothing in this section relieves the Contractor of its obligation to resolve the Enrollee's Appeal as expeditiously as the Enrollee's health condition requires, in accordance with Federal and State laws, regulations, rules, policies, procedures, and manuals.

2.15.3.4.5 In the case of an expedited Appeal denial, the Contractor shall provide oral notice to the Enrollee by close of business on the day of resolution and written notice to the Enrollee within two (2) Calendar Days of the disposition.

2.15.3.5 Extension of Timeframes

2.15.3.5.1 The Contractor may extend the timeframes for resolution of Appeals by up to fourteen (14) Calendar Days if:

2.15.3.5.1.1 The Enrollee requests the extension; or

2.15.3.5.1.2 The Contractor shows (to the satisfaction of LDH, upon its request) that there is a need for additional information and how the delay is in the best interest of the Enrollee.

2.15.3.5.2 If the timeframe is extended other than at the Enrollee's request, the Contractor shall complete all of the following:

2.15.3.5.2.1 Provide oral notice of the extension to the Enrollee by close of business on the day the Contractor decides to extend the timeframe;

2.15.3.5.2.2 Provide written notice of the reason for the extension within two (2) Calendar Days after the Contractor decides to extend the timeframe. The written notice shall also

inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and

2.15.3.5.2.3 Resolve the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

2.15.3.6 Notice of Appeal Resolution

2.15.3.6.1 The Contractor shall provide the Enrollee with a written notice of Appeal resolution using a template approved by LDH in writing.

2.15.3.6.2 The Contractor shall include on the notice a unique identifying number, corresponding to the number on the notice of Adverse Benefit Determination that gave rise to the Appeal.

2.15.3.6.3 For Appeals not resolved wholly in favor of the Enrollees, the notice shall include all information required under 42 CFR §438.408, including, but not limited to, informing the Enrollee of their right to seek a State Fair Hearing if the Enrollee is not satisfied with the Contractor's decision in response to an Appeal, and the process for doing so.

2.15.4 Process for State Fair Hearings

2.15.4.1 An Enrollee or other party to the Appeal, who has completed the Contractor's Appeal Procedure, may request a State Fair Hearing within one hundred twenty (120) Calendar Days after receiving a notice of Appeal resolution indicating that the Contractor is upholding, in whole or in part, the Adverse Benefit Determination, or after the Contractor fails to adhere to the notice and timing requirements applicable to Appeals.

2.15.4.2 The Contractor shall attend State Fair Hearings as scheduled and supply the necessary witnesses and evidentiary materials.

2.15.4.3 The Contractor shall submit an evidence packet to LDH and to the Enrollee, free of charge, within seven (7) Business Days from the time the Contractor receives notification of the hearing. The evidence packet shall be submitted to LDH in accordance with any prehearing instructions. The evidence packet shall include all necessary documents including the statement of matters (or, alternatively, the denial letter) and any medical records or other documents and/or records considered or relied upon by the Contractor and supporting the Contractor's Adverse Benefit Determination and Appeal resolution.

2.15.4.4 Within two (2) Business Days of notification of the State Fair Hearing request, the Contractor shall provide the corresponding Notice of Adverse Benefit Determination and the Notice of Appeal Resolution that relate to the State Fair Hearing request to LDH.

2.15.4.5 The Contractor shall designate an email address for all State Fair Hearing-related communications from LDH and any party to the State Fair Hearing.

2.15.4.6 The Contractor shall continue the Enrollee's benefits while the State Fair Hearing is pending if the Enrollee Timely files for continuation of benefits within ten (10) Calendar Days after the Contractor sends the notice of Appeal resolution that is not wholly in the Enrollee's favor, in accordance with 42 CFR §438.420(b).

2.15.4.7 The Contractor shall comply with all terms and conditions set forth in any orders and instructions issued by an administrative law judge.

2.15.4.8 If, at the Enrollee's request, the Contractor continues or reinstates the benefits while the State Fair Hearing is pending, the benefits shall continue until one (1) of the following occurs:

2.15.4.8.1 The Enrollee withdraws the State Fair Hearing request;

2.15.4.8.2 The State Fair Hearing officer issues a hearing decision adverse to the Enrollee.

2.15.4.9 If the Contractor's action is reversed by the administrative law judge and services were not furnished while the Appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours from the date the Contractor receives the notice reversing the determination.

2.15.4.10 The Contractor shall not create barriers to Timely due process. The Contractor shall be subject to penalties if it is determined by LDH that the Contractor has created barriers to Timely due process, and/or, if ten percent (10%) or higher of denied Appeals are reversed or otherwise resolved in favor of the Enrollee following a State Fair Hearing within a calendar year. Examples of creating barriers shall include, but not be limited to:

2.15.4.10.1 Labeling Grievances as inquiries and funneling them into an informal review;

2.15.4.10.2 Failure to inform Enrollees of their rights to file Grievances, Appeals, and State Fair Hearings;

2.15.4.10.3 Failure to log and process Grievances and Appeals;

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

2.15.4.10.5 Failure to inform of continuation of benefits.

2.15.4.11 The Contractor shall take no punitive action against a provider who either requests an expedited resolution on behalf of an Enrollee or supports an Enrollee's Appeal.

2.16 Quality Management and Quality Improvement

LDH's Medicaid Managed Care Quality Strategy ("Quality Strategy") defines and drives the overall vision for advancing health outcomes and quality of care provided to Enrollees. It establishes clear aims, goals, and objectives to drive improvements in care delivery and the outcomes and metrics by which progress will be measured. It articulates priority areas for quality improvement, and details the standards and mechanisms for desired outcomes, integration with population health priorities, and the advancement of health equity through reduction of health disparities. The Quality Strategy is a roadmap by which LDH shall use the managed care infrastructure to facilitate improvement in the clinical and non-clinical drivers of health, incentivizing the Contractor to attain quality goals and improve health outcomes.

2.16.1 General Requirements

2.16.1.1 The Contractor's Quality Management (QM) and Quality Improvement (QI) and QAPI programs shall align with LDH's priorities, goals and objectives as detailed in the Quality Strategy.

2.16.1.2 The Contractor shall deliver quality care that enables Enrollees to maintain good health, prevent poor health outcomes and, if necessary, manage a chronic illness or disability. Quality care refers to:

2.16.1.2.1 Clinical quality of physical health care;

2.16.1.2.2 Clinical quality of behavioral health care focusing on recovery, resilience and rehabilitation;

2.16.1.2.3 Access and availability of primary and specialty care providers and services;

2.16.1.2.4 Continuity and coordination of care across settings and care transitions; and

2.16.1.2.5 Enrollee experience with respect to quality, access, availability, cultural and linguistic appropriateness of services, and continuity and coordination of care.

2.16.1.3 The Contractor shall apply the principles of continuous quality improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

2.16.1.3.1 Quantitative and qualitative data collection with data-driven decision-making;

2.16.1.3.2 Up-to-date evidence-based practice guidelines consisting of explicit criteria developed by professional societies or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

2.16.1.3.3 Feedback provided by Enrollees and providers in the design, planning, and implementation of CQI activities;

2.16.1.3.4 Issues identified by the Contractor or LDH; and

2.16.1.3.5 QM/QI requirements of this Contract applied to the delivery of physical health services, behavioral health services and applied behavior analysis.

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2.16.1.4 The Contractor's QM/QI organizational and program structure shall comply with all applicable provisions of 42 CFR Part 438, including, but not limited to, Subparts D and E.

2.16.1.5 The Contractor shall annually measure and report to the State on its performance, using the standard measures required by the State, and submit data to the State, as specified in this section.

2.16.2 Quality Assessment and Performance Improvement Program

2.16.2.1 The Contractor shall establish and implement a QAPI Program, as required by this Contract and 42 CFR §438.330(a)(1).

2.16.2.2 The QAPI Program shall clearly define QM/QI structures and processes and assign responsibility to appropriate individuals.

2.16.2.3 At a minimum, the QAPI Program shall:

2.16.2.3.1 Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities, including, but not limited to, improving the Contractor's performance on measures specified in Attachment H, *Quality Performance Measures*;

2.16.2.3.2 Incorporate improvement strategies and performance improvement projects as defined by LDH;

2.16.2.3.3 Detect and address underutilization of high value services and overutilization of low value services, as guided by the Quality Strategy. The Contractor shall work collaboratively with LDH to prioritize specific efforts anticipated to improve high quality, cost-effective care for Enrollees. The Contractor shall implement at least one (1) initiative to reduce low-value care in a targeted area through coordination with Network Providers, including provider and member education efforts. Within the first year of the Contract's Operational Start Date, the Contractor shall propose its initiative to reduce low-value care in a targeted area, subject to LDH approval in writing, based on feasibility, thoughtfulness of approach to Enrollee and provider engagement, consistency with priorities of the Quality Strategy, and alignment with nationally validated initiatives and frameworks.

2.16.2.3.4 Include collection and submission of performance measurement data in accordance with 42 CFR §438.330(c);

2.16.2.3.5 Address the quality of MCO Covered Services, including physical health and behavioral health services;

2.16.2.3.6 Include the Contractor's plan for improving the quality of care and patient safety based on improvement in health outcomes, rather than process or utilization outcomes;

2.16.2.3.7 Incorporate applicable reporting and monitoring requirements and activities;

2.16.2.3.8 Include mechanisms to assess the quality and appropriateness of care furnished to Enrollees with SHCN;

2.16.2.3.9 Include specific mechanisms to assess the quality and appropriateness of care provided to Enrollees at risk for health disparities due to: race, ethnicity, sex, primary language, and sexual orientation;

2.16.2.3.10 Include QM/QI activities to improve health care disparities identified through data collection;

2.16.2.3.11 Detail the Contractor's Provider Support Plan; and

2.16.2.3.12 Be evaluated and updated at least annually by the Contractor.

2.16.2.4 The Contractor shall use the results of QAPI activities to improve the quality of physical health and behavioral health service delivery with appropriate input from Enrollees and providers. The Contractor's annual QAPI report shall describe how the Contractor solicited direct input from Enrollees and providers and how the results of QAPI activities improved the quality of service delivery.

2.16.2.5 The Contractor shall submit its QAPI Program description to LDH for written approval at least thirty (30) Calendar Days prior to the Operational Start Date, and at least annually for the term of the Contract. The QAPI Program description shall include an annual QM/QI Work Plan that addresses issues identified by the Contractor, LDH, Enrollees, and providers, and how those issues are tracked and resolved over time.

2.16.3 QAPI Governance

2.16.3.1 The Contractor's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the Contractor's governing body shall include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the Contractor.

2.16.3.2 The Contractor shall have sufficient mechanisms in place to solicit QM/QI feedback and recommendations from key stakeholders, Enrollees and their families/caregivers, and Network Providers, and use feedback and recommendations to improve performance.

2.16.3.3 The Contractor shall disseminate information about QAPI findings and improvement actions taken and their effectiveness to LDH and other key stakeholders as directed by LDH. At LDH's request, the Contractor may be required to conduct special focus studies.

2.16.3.4 The Contractor shall increase the alignment of assessment and treatment of medical conditions with best practice standards through policies.

2.16.3.5 The Contractor shall conduct peer review to evaluate the clinical competence and quality and appropriateness of medical care and services provided to Enrollees. The Contractor shall provide peer review documentation to LDH, upon request.

2.16.3.6 The Contractor shall have appropriate staff participate in the LDH Quality Committee meetings and other quality improvement-related meetings and workgroups, as directed by LDH and shall establish and implement policies and procedures in order to address specific quality concerns.

2.16.4 QAPI Committee

The Contractor shall form a QAPI Committee that shall at a minimum include:

2.16.4.1 The Contractor's Medical Director who must serve as either the chairman or co-chairman;

2.16.4.2 The Contractor's Behavioral Health Director;

2.16.4.3 Substantial involvement of medical and behavioral health providers serving the Contractor's Enrollees;

2.16.4.4 Appropriate Contractor medical and behavioral health staff representing the various departments of the organization; and

2.16.4.5 An Enrollee representative(s) and/or advocate(s).

The Contractor shall provide the Medicaid Medical Director with ten (10) Calendar Days advance notice of all regularly scheduled meetings of the QAPI Committee. The Medicaid Medical Director, OBH Medical Director, OBH Director of Quality Management, Medicaid Quality Improvement Section Chief, OCDD Clinical Director, OAAS Assistant Secretary, or his/her designee(s), may attend the QAPI Committee meetings at his/her option.

2.16.5 QAPI Committee Responsibilities

The QAPI Committee shall meet on at least a quarterly basis. Its responsibilities shall include:

2.16.5.1 Direct and review QM/QI activities and the QAPI Program overall;

2.16.5.2 Ensure that QAPI activities take place throughout the Contractor's organization and ensure that providers are involved in the QAPI Program;

2.16.5.3 Review and evaluate results of the QM/QI activities, recommend policy decisions, and suggest new and/or improved QM/QI activities;

2.16.5.4 Create and direct task forces/committees to identify, review, and address areas of concern in the provision of health care services to Enrollees, including instituting needed action and ensuring that appropriate follow-up occurs;

2.16.5.5 Designate evaluation and study design procedures;

2.16.5.6 Review provider network performance, including individual PCP, specialized behavioral health provider, and practice quality performance measure profiling to identify and address patterns;

2.16.5.7 Report findings to appropriate executive authority, staff, and departments within the Contractor's organization;

2.16.5.8 Direct and analyze periodic reviews of Enrollees' service utilization patterns;

2.16.5.9 Maintain written minutes of all committee and sub-committee meetings and submit meeting minutes to LDH. A copy of the signed and dated written minutes for each meeting shall be available after the minutes are approved and shall be available for review upon request and during EQRO reviews and during NCQA accreditation reviews;

2.16.5.10 Report an evaluation of the impact and effectiveness of the QAPI Program to LDH annually;

2.16.5.11 Ensure that the QAPI Committee chair, and/or the appropriate designee, participates in LDH's Quality Committee meetings and other quality related meetings as required by this section of this Contract;

2.16.5.12 Work with other Contractor staff and Subcontractors to establish policies and procedures to address specific quality concerns as required by this section of this Contract; and

2.16.5.13 Update provider manuals and other relevant clinical content on a periodic basis as often as determined necessary by the committee chairperson.

The Contractor shall take appropriate action to address service delivery, provider, and other QM/QI issues as they are identified, including, but not limited to, discussing and addressing identified quality of care concerns during regular and ad hoc QAPI Committee meetings.

2.16.6 QAPI Plan

The QAPI Committee shall develop and implement a written QAPI Plan that incorporates the strategic direction provided by the governing body. The QAPI Plan shall be submitted to LDH or its designee as part of Readiness Review and annually thereafter, and prior to implementation of revisions. The QAPI Plan, at a minimum, shall:

2.16.6.1 Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;

2.16.6.2 Include processes and metrics to evaluate the impact and effectiveness of the QAPI Program;

2.16.6.3 Include a description of the Contractor staff assigned to the QAPI Program, their specific training, their organizational structure, and their responsibilities;

2.16.6.4 Describe the role of Network Providers and Enrollees in providing input to the QAPI Program;

2.16.6.5 Be exclusive to the Louisiana Medicaid Program and shall not contain documentation from other State Medicaid programs or product lines operated by the Contractor; and

2.16.6.6 Describe the methods for ensuring data collected and reported to LDH is valid, accurate, and reflects Network Providers' adherence to clinical practice guidelines as appropriate.

2.16.7 QAPI Reporting Requirements

2.16.7.1 The Contractor shall submit QAPI reports at least annually to LDH which, at a minimum, shall include:

2.16.7.1.1 Quality improvement (QI) activities;

2.16.7.1.2 Recommended new and/or improved QI activities; and

2.16.7.1.3 Results of the evaluation of the impact and effectiveness of the QAPI Program.

2.16.7.2 LDH reserves the right to request additional reports as deemed necessary. LDH will notify the Contractor of additional required reports no less than sixty (60) Calendar Days prior to the due date of those reports.

2.16.7.3 The Contractor shall provide all reports required under this subsection, including, but not limited to, ad-hoc reports and reports for special populations to LDH using the specifications and format approved by LDH in writing. The Contractor shall submit the reports based on the agreed upon dates established by the Contractor and LDH.

2.16.8 Performance Measures

2.16.8.1 Annually, the Contractor shall report on all HEDIS measures designated by LDH in Attachment H, *Quality Performance Measures*. The Contractor shall contract with an NCQA-certified HEDIS auditor to validate the processes of the Contractor in accordance with NCQA requirements. Audited HEDIS results shall be submitted to LDH, NCQA and LDH's EQRO

annually according to NCQA's data submission timeline for health plans to submit final Medicaid HEDIS results.

2.16.8.2 LDH has the sole discretion to determine whether the Contractor will be granted an exception from obtaining a HEDIS audit and/or from submitting the results of the HEDIS audit to NCQA for either some or all of the quality and health outcome measurements. If such an exception is granted in writing, the Contractor shall comply with all instructions and deadlines provided by LDH.

2.16.8.3 The Contractor shall report on additional non-HEDIS performance measures listed in and as specified in Attachment H, *Quality Performance Measures*.

2.16.8.4 Reporting of quality measures shall include stratification of performance measure results across different populations with attention to geography, ethnicity, race, and as reasonably directed by LDH.

2.16.8.5 The Contractor shall have processes in place to monitor, self-report, and implement CQI on all performance measures.

2.16.8.6 The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.

2.16.8.7 The Contractor shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.

2.16.8.8 The tools and reports shall be flexible and adaptable to changes in the quality measurements required by LDH.

2.16.8.9 The Contractor shall maintain integrity, accuracy, and consistency in data reported. Upon request, the Contractor shall submit to LDH details sufficient to independently validate the data reported.

2.16.9 Incentive Based Performance Measures

2.16.9.1 Incentive Based (IB) performance measures are measures that may affect PMPM payments and can be identified in Attachment H, *Quality Performance Measures*, annotated with "$$".

2.16.9.2 LDH expressly reserves the right to modify IB performance measures. Any changes in the IB performance measures shall require an amendment to the Contract and LDH shall notify Contractor of such change prior to the start of the Measurement Year.

2.16.9.3 The Contractor shall have the ability to update national standard code sets such as CPT/HCPCS, ICD-10-CM, and move to future versions as required by CMS or LDH. Updates to code sets are to be complete no later than thirty (30) Calendar Days after notification of inclusion on LDH fee

schedule, unless otherwise directed by LDH in writing. This includes annual and other fee schedule updates.

2.16.10 Performance Measure Monitoring

2.16.10.1 The Contractor shall submit administrative Encounter Data to LDH or its designee upon request in a format that facilitates monitoring of the Contractor's performance on quality measures and benchmarks.

2.16.10.2 During the course of the Contract, the Contractor shall actively participate with LDH or its designee to review the results of performance measures.

2.16.10.3 Corrective action may be required for performance measures that do not reach the Department's performance benchmark. LDH has the sole discretion to determine the standards by which the Contractor shall be surveyed and evaluated.

2.16.10.4 LDH may impose Monetary Penalties, sanctions and/or restrict Enrollment pending attainment of acceptable quality of care.

2.16.11 Performance Improvement Projects

2.16.11.1 The Contractor shall implement an ongoing program of Performance Improvement Projects (PIPs) that focus on clinical and non-clinical performance measures as specified in 42 CFR §438.330. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care; non-clinical PIPs include projects focusing on availability, accessibility, low-value care, addressing SDOH, and cultural competency of services.

2.16.11.2 The Contractor shall perform at least three (3) LDH-approved PIPs of which at least one must be a behavioral health PIP. LDH may require the Contractor to perform up to two (2) additional projects for a maximum of five (5) projects.

2.16.11.3 At LDH's request, prior to initiation of each LDH-directed PIP, the Contractor shall submit in writing a PIP proposal, in compliance with the **MCO Manual**, for written approval by LDH approval.

2.16.11.4 The Contractor shall, in collaboration with LDH, identify benchmarks and set achievable performance goals for each of its PIPs. The Contractor shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP and promoting sustained improvements.

2.16.11.5 PIPs shall be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with

favorable effects on health outcomes and Enrollee satisfaction. Each project must involve the following:

2.16.11.5.1 Measurement of performance using objective quality indicators;

2.16.11.5.2 Implementation of interventions to achieve improvement in the access to and quality of care;

2.16.11.5.3 Evaluation of the effectiveness of the interventions; and

2.16.11.5.4 Planning and initiation of activities for increasing or sustaining improvement.

2.16.11.6 LDH, in consultation with CMS and other stakeholders, may require specific performance measures and PIP topics. The Contractor shall report the status and results of each PIP as specified in the **MCO Manual**. If CMS specifies a PIP, the Contractor shall implement this PIP, and it shall count toward the state-approved projects.

2.16.11.7 The Contractor shall complete each project shall within in a reasonable time within the performance period to allow the Contractor to utilize aggregate information on the success of PIPs to develop action plans to implement future PIPs that will most effectively improve quality.

2.16.12 Enrollee Satisfaction Surveys

2.16.12.1 The Contractor shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys.

2.16.12.2 The Contractor shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys.

2.16.12.3 The Contractor's vendor shall perform CAHPS Adult surveys and CAHPS Child surveys, including the Children with Chronic Conditions survey supplement.

2.16.12.4 Survey results and a description of the survey process shall be reported to LDH separately for each required CAHPS survey. CAHPS survey results shall be submitted to LDH, NCQA and LDH's EQRO annually according to NCQA's data submission timeline for health plans to submit final Medicaid CAHPS results.

2.16.12.5 The CAHPS survey results shall be reported to LDH or its designee for each survey question. These results may be used by LDH for public reporting. Responses shall be aggregated by LDH or its designee for reporting. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the Contractor at the time of the survey.

2.16.12.6 The surveys shall provide valid and reliable data for results.

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

2.16.12.8 The most current CAHPS Health Plan Survey for Enrollees shall be used and include:

2.16.12.8.1 Getting Needed Care;

2.16.12.8.2 Getting Care Quickly;

2.16.12.8.3 How Well Doctors Communicate;

2.16.12.8.4 Health Plan Customer Service; and

2.16.12.8.5 Global Ratings.

2.16.13 External Review and Oversight of Contractor

2.16.13.1 The Contractor shall fully cooperate with LDH, CMS, LDH's EQRO and Outcomes Research and Evaluation contractors, and any other LDH designees related to reviewing, evaluating, and monitoring of this Contract, the Contractor, or the Managed Care Program.

2.16.13.2 The Contractor shall provide all information requested by LDH and/or its EQRO including, but not limited to, quality outcomes, quality improvement processes, timeliness of, and Enrollee access to, MCO Covered Services, network adequacy and NCQA accreditation status.

2.16.13.3 The Contractor shall comply with the EQRO's requests for information including, but not limited to, a review of the Contractor's QAPI Committee meeting minutes and annual medical record audits to ensure that it provides quality and accessible health care to Contractor Enrollees, in accordance with standards contained in the Contract. Such audits shall allow LDH or its designee to review individual medical records, identify and collect management data including, but not limited to, surveys and other information concerning the use of services and the reasons for Disenrollment.

2.16.13.4 The standards by which the Contractor shall be surveyed and evaluated by the EQRO shall be at the sole discretion and approval of LDH. If deficiencies are identified, LDH shall determine the remedy or remedies as outlined in the *Contract Non-Compliance* section.

2.16.13.5 If the EQRO indicates that the quality of care is not within acceptable limits set forth in the Contract, LDH may penalize the Contractor in accordance with the Contract and may immediately terminate all Enrollment activities and Automatic Assignment until the Contractor attains a satisfactory level of quality of care as determined by the EQRO and LDH.

2.16.13.6 The Contractor shall include a description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQRO findings in the Contractor's QAPI Program.

2.16.14 Health Plan Accreditation

2.16.14.1 If the Contractor is NCQA accredited for its Medicaid product covered by this Contract as of the Operational Start Date, the Contractor shall maintain full NCQA accreditation throughout the term of this Contract.

2.16.14.2 If the Contractor is not NCQA accredited for its Medicaid product covered by this Contract by the Operational Start Date, the Contractor shall attain such accreditation.

2.16.14.3 The Contractor's application for NCQA accreditation shall be submitted at the earliest point allowed by the organization. The Contractor shall provide LDH with a copy of all correspondence with NCQA regarding the application process and the accreditation requirements.

2.16.14.4 Within ten (10) Calendar Days of receipt of the final hard copy NCQA Accreditation report for each accreditation cycle, the Contractor shall provide LDH with a copy of its final accreditation report including:

2.16.14.4.1 Accreditation status, survey type, and level (as applicable);

2.16.14.4.2 Accreditation results, including recommended actions or improvements, Corrective Action Plan(s), and summaries of findings; and

2.16.14.4.3 Expiration date of the accreditation.

2.16.14.5 The Contractor shall provide LDH with updates of its NCQA accreditation status if there are any changes within the accreditation period or upon request by LDH.

2.16.14.6 If the Contractor achieves provisional accreditation status from NCQA:

2.16.14.6.1 LDH may restrict automatic and voluntary Enrollment in the Contractor's plan; and

2.16.14.6.2 LDH shall require the Contractor to initiate a Corrective Action Plan within thirty (30) Calendar Days of receipt of the Final Report from NCQA and work to address the findings contributing to the provisional accreditation status.

2.16.14.7 The Contractor's failure to attain full NCQA accreditation under this Contract or failure to maintain full NCQA accreditation at any time may be considered a breach of the Contract and may result in termination of the Contract.

2.16.14.8 If the Contractor subcontracts with a third party (which is either a part of the Contractor's parent organization or wholly independent) for behavioral health services, the Subcontractor shall be accredited by NCQA as a managed behavioral health organization, or be working towards receiving full NCQA accreditation within the Contract term.

2.16.15 Enrollee Advisory Council

As specified in **the MCO Manual**, the Contractor shall establish an Enrollee Advisory Council to enhance the service delivery system, improve Enrollee experience, and allow participation in providing input on policy and programs. Such Council shall be in compliance with the requirements in the **MCO Manual**.

2.16.16 Provider Supports for Quality Improvement

2.16.16.1 The Contractor shall provide support to providers tailored to advance State priorities and ensure providers' ability to achieve the goals outlined in the Quality Strategy. Such supports shall assist providers in clinical transformation and care improvement efforts at a regional and practice level.

2.16.16.2 As part of the Contractor's QAPI Plan, it shall develop and maintain a Provider Support Plan, which shall be updated on an annual basis. The Provider Support Plan shall:

2.16.16.2.1 Be developed as a component of the QAPI Program; provider support activities should relate to improvement in specific health outcomes; and

2.16.16.2.2 Include: (a) a list of provider supports; (b) how the Contractor will provide in-person, online, and practice-level and regional collaborative support opportunities; (c) all planned technical support activities including the Contractor's plan for sharing relevant data; (d) metrics to evaluate provider engagement and related improvements; and (e) detailed information regarding how its proposed provider supports activities will advance the aims, goals, and objectives outlined within the Quality Strategy.

2.16.16.3 The Contractor shall provide quality improvement support to Network Providers during the initiation and implementation of quality and population health interventions, as outlined in the Quality Strategy and in coordination with the Louisiana Medicaid Quality Committee, or as otherwise specified by LDH.

2.16.16.4 The Contractor shall provide an opportunity for providers (in-person, online, routine/ad-hoc) to raise local challenges and exchange best practices related to quality and population health interventions, as outlined in the Quality Strategy and other LDH transformation initiatives.

2.16.16.5 The Contractor shall communicate with the Medicaid Medical Director or designated primary contact in order to raise regional issues related to

quality and population health interventions, as outlined in the Quality Strategy and as otherwise specified by LDH.

2.16.17 Fidelity to Evidence-Based Practices in Behavioral Health Care

2.16.17.1 The Contractor shall establish a fidelity-monitoring plan for Evidenced Based Practice providers to ensure providers' adherence to evidence-based and evidence-informed practices to ensure the core elements of the intervention are maintained and minimum fidelity standards are met.

2.16.17.2 A formal fidelity-monitoring plan shall be submitted to LDH or its designee as part of Readiness Review, which demonstrates compliance with the requirements for fidelity monitoring as specified in the **MCO Manual**.

2.16.18 Best Practices in Children's Behavioral Health Residential Treatment

The Contractor shall advance initiatives aimed at increased alignment of children's behavioral health residential programming with national best practice standards. The Contractor shall utilize authorization, continued stay review, and discharge planning protocols that support the implementation of best practices, including family engagement throughout the residential treatment episode, proactive discharge planning including referral to CSoC (if appropriate) sixty (60) Calendar Days prior to anticipated discharge to a home setting, and ensuring that aftercare providers have been identified thirty (30) Calendar Days prior to discharge so that aftercare services begin immediately upon discharge to a home setting. The Contractor shall participate in planning and implementation of these initiatives with LDH, and collaborate to develop an implementation monitoring plan and provide assistance to providers in collecting and reporting on best practice-related performance indicators.

2.16.19 Adverse Incident and Quality of Care Concerns Management and Reporting

2.16.19.1 The Contractor shall develop and implement adverse incident management policies and procedures for specialized behavioral health providers, which enable the Contractor to identify and address Enrollee service gaps; Timely identify, address, and remediate harms; assess the effectiveness of the corrective or remedial actions, and reduce risks of recurrent harm.

2.16.19.2 The Contractor shall establish reporting and investigation protocols for quality of care concerns, and report such concerns to LDH. The Contractor shall provide training, on no less than an annual basis, to specialized behavioral health providers on adverse incident management and reporting requirements.

2.16.19.3 The Contractor shall require specialized behavioral health providers to report adverse incidents as specified in the **MCO Manual** and within the required timeframe.

2.16.19.4 As requested by LDH, the Contractor shall obtain Enrollee records and other documentation from Network Providers, and submit such information to LDH within the requested timeframe.

2.16.19.5 The Contractor will ensure remedial and corrective actions requested by LDH are implemented Timely and appropriately.

2.16.20 Outcome Assessment for Behavioral Health Services

2.16.20.1 The Contractor shall assess the treatment progress and effectiveness of SBHS for both children and adults using standardized clinical outcome tools and measures, according to the guidelines in the **MCO Manual**.

2.16.20.2 The Contractor shall ensure providers and appropriate Contractor staff are adequately trained and/or certified in the use of such tools and such training and/or certification is current.

2.16.20.3 The Contractor shall be responsible for collection of outcome data, data validation activities, and reporting to LDH.

2.16.21 Managed Care Incentive Program

2.16.21.1 LDH may make incentive payments of up to five percent (5%), in total, above the approved Capitation Payments attributable to the Enrollees or services covered by the Approved Incentive Arrangements (AIAs) implemented by LDH. These incentive payments will support the activities, targets, performance measures, or quality-based outcomes specified in LDH's Quality Strategy.

2.16.21.2 The Contractor shall participate in the AIAs implemented by LDH. At the Contractor's sole discretion, the Contractor may subcontract with one or more third parties to assist in its achievement of those AIAs. The subcontract should include specific provisions pertaining to the rights and obligations of the Contractor and such third parties; eligibility for participation; payment amount and timing; recovery of payments (including the amount, time and manner/method); and other such terms particular to that AIA as mutually agreed upon in the Contract between the Contractor and such third party.

2.16.21.3 LDH will, for each AIA to be implemented, specify the activities, targets, performance measures, or quality-based outcomes to be achieved and how each will be evaluated. LDH will only implement AIA that are consistent with 42 CFR §438.6(b)(2) and this Section, including:

2.16.21.3.1 AIAs will be for a fixed period of time and performance will be measured during the rating period under the Contract in which the AIA is applied.

2.16.21.3.2 AIAs will not be renewed automatically.

2.16.21.3.3 AIAs will be made available to both public and private contractors under the same terms of performance.

2.16.21.3.4 Neither the Contractor's participation in the MCIP, nor any AIA, will be conditioned on the Contractor entering into or adhering to an intergovernmental transfer agreement.

2.16.21.3.5 AIAs are necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the Quality Strategy.

2.16.21.4 Each AIA shall define the quality strategy objectives.

2.16.21.5 For each Measurement Year, LDH will evaluate performance relative to the specified activities, targets, performance measures, or quality-based outcomes to be achieved for the AIA. LDH's evaluation will be based on documentation, submitted by the Contractor, reflecting performance.

2.16.21.6 LDH shall Timely notify the Contractor regarding achievement for the specified activities, targets, performance measures or quality-based outcomes for the AIA for that Measurement Year. In the event LDH finds a deficiency, LDH will notify the Contractor of its findings, including the portion of the incentive payments made attributable to such deficiency. Upon request of the Contractor, LDH may defer recoupment, and the Contractor and LDH may confer regarding LDH's findings, proposed action and opportunity for cure. Upon final determination by LDH, which shall not be subject to Appeal, LDH may recoup from the Contractor the portion of the incentive payments made attributable to any uncured deficiency. All LDH recoupments made from the Contractor pursuant to this Section shall be made in accordance with the recoupment terms established by LDH, which terms shall be provided to the Contractor in writing at least thirty (30) Calendar Days in advance of LDH recoupment from the Contractor.

2.16.21.7 The Contractor shall ensure that any subcontracts the Contractor may have with any third party to fulfill the obligations under this Section contain provisions clearly providing for the Contractor's right of recovery in situations whereby LDH recoups MCIP payments from the Contractor. LDH reserves the right to recoup in any situation where CMS disallows Federal Financial Participation related to any payments in the MCIP. The Contractor's activities to recover such payments from its Subcontractor, through recoupment, withhold or otherwise, are not subject to the prior notification requirement under the *Fraud, Waste, and Abuse Prevention* section, or any other notice and reporting obligation set forth in this Contract unless otherwise required by the terms of recoupment specified by LDH under this Section.

2.16.21.8 The Contractor's participation in the AIAs shall have no impact on the Contractor's rights or obligations under this Contract, except as it relates specifically to the MCIP. The Contractor's participation in an AIA does not

represent a binding obligation on the Contractor to achieve the approved targeted health outcomes, and failure to achieve such outcomes shall not be considered a breach of this Contract. Further, except for recoupment of MCIP payments, either directly or via offset, no penalty shall be applied for failure to achieve targeted outcomes. The aforementioned penalty limitation shall not apply to instances of the Contractor's fraudulent conduct. In the event of a conflict with other terms of this Contract, the provisions of this Section and LDH's MCIP Protocol shall prevail.

2.16.22 Quality Monitoring Reviews

The Contractor shall collaborate with the other MCOs to develop and implement a plan for monitoring a representative sample of specialized behavioral health providers and facilities across levels of care, which incorporates onsite reviews and member interviews, on a quarterly basis. The Contractor shall submit the plan to LDH for approval no later than sixty (60) Calendar Days after the Operational Start Date of the Contract and at least sixty (60) Calendar Days prior to any Material Change. The Contractor's monitoring plan, monitoring process, and sampling approach shall comply with the requirements as specified by LDH in the **MCO Manual**.

2.17 Value-Based Payment

2.17.1 Value-Based Payment (VBP) Overview

The Contractor shall develop and implement a VBP Strategic Plan for achieving the performance benchmarks in this Contract and paying providers based on performance. The Contractor's VBP strategy shall pertain to measurable outcomes that are meant to improve the health of populations (better health), enhance the experience of care for individuals (better care), effectively manage Louisiana Medicaid Program per capita care costs (lower costs).

In developing its VBP Strategic Plan, the Contractor shall refer to this Contract, the **MCO Manual** and the Alternative Payment Method (APM) Framework developed by the Health Care Payment Learning and Action Network (HCP-LAN).

2.17.2 Qualifying VBP Arrangements

The Contractor may only report a provider payment model as a VBP arrangement if the following conditions are met:

2.17.2.1 The payment model includes a Category 2A foundational payment or Category 2B pay for reporting as one component of a broader payment model that includes Category 2C, 3, or 4 APMs for the same provider(s); and/or

2.17.2.2 The payment model falls within Categories 2C, 3 or 4 of the HCP-LAN APM Framework; and

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Deleted: and be designed to meet or exceed the VBP withhold requirements in this Contract.

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Deleted: <#>Minimum VBP Threshold and Qualifying VBP Arrangements¶
<#>A portion of the Contractor's annual VBP withhold described in the *Financial Incentives for MCO Performance* section shall be tied to the Contractor's demonstration that it has met the minimum VBP threshold established as defined by LDH in accordance with this Contract. Unless otherwise modified by LDH, the minimum VBP threshold for each Measurement Year is as described in the *Financial Incentives for MCO Performance* section.

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2.17.2.3 The payment model is linked to at least two (2) applicable measures from Attachment H, *Quality Performance Measures*.

2.17.2.4 VBP models focused on PCPs must include at least two incentive-based measure from Attachment H, *Quality Performance Measures*. VBP arrangements focused on services other than primary care must utilize at least two applicable measures in Attachment H, *Quality Performance Measures*, and these measures do not need to be identified as incentive-based measures. If there are not at least two applicable measures in Attachment H, *Quality Performance Measures*, the Contractor must justify its rationale for selecting different VBP measures and must seek approval from LDH to include the VBP arrangement in its submission of Attachment E, *APM Reporting Template*.

2.17.3 Physician Incentive Plans

2.17.3.1 In accordance with 42 CFR §422.208 and §422.210, the Contractor may operate a Physician Incentive Plan, but specific payment cannot be made directly or indirectly under a Physician Incentive Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

2.17.3.2 The Contractor's Physician Incentive Plans shall be in compliance with 42 CFR §438.3(i), §422.208, and §422.210 and this Contract.

2.17.3.3 Any sub-capitation arrangement with Network Providers is considered a Physician Incentive Plan and subject to Federal requirements and requirements of this section.

2.17.3.4 The Contractor shall report to LDH twice annually on all Physician Incentive Plans it operates, and those Physician Incentive Plans that it intends to operate within the next six (6) months. The Contractor's Physician Incentive Plan report is due on February 1 and August 30 of each year and in accordance with LDH instructions and templates. In each of these reports, the Contractor shall:

2.17.3.4.1 Provide a written assurance to LDH that either:

2.17.3.4.1.1 The Contractor is not operating any Physician Incentive Plans that put physicians and physician groups at "substantial financial risk" as defined in 42 CFR §422.208; or

2.17.3.4.1.2 The Contractor is operating Physician Incentive Plans that put physicians and physician groups at "substantial financial risk" as defined in 42 CFR §422.208 and those plans meet all applicable Federal requirements.

2.17.3.4.2 Report to LDH the following information in sufficient detail to determine whether each existing and proposed Physician Incentive Plan complies with the regulatory requirements including:

2.17.3.4.2.1 Whether services not furnished by the physician or physician group are covered by the Physician Incentive Plan. No further disclosure is required if the Physician Incentive Plan does not cover services not furnished by the physician or physician group;

2.17.3.4.2.2 The type of incentive arrangement (e.g., withhold, bonus, capitation arrangement, etc.) and the percent of withhold or bonus, if applicable;

2.17.3.4.2.3 If the physician or physician group is at substantial financial risk, proof the physician or physician group has adequate stop-loss protection, including the amount and type of stop-loss protection; and

2.17.3.4.2.4 An explanation and the results of Enrollee surveys in accordance with 42 CFR §417.479.

2.17.3.5 The Contractor shall provide the information specified in 42 CFR §422.210(b) regarding its Physician Incentive Plans to any Enrollee upon request.

2.17.4 VBP Data Sharing and Collaborative Efforts

2.17.4.1 The Contractor shall work collaboratively with LDH, providers, and with other MCOs to develop common measure specifications, address Attribution challenges, and work to align data collection processes, baseline data, and reports for providers engaged in VBP arrangements.

2.17.4.2 The Contractor shall dedicate resources for provider outreach and education related to VBP models, primary care practice transformation, assistance with data and report interpretation, and other activities to support provider's VBP readiness and performance improvement.

2.17.4.3 The Contractor shall implement processes to share data and performance reports with participating VBP providers on a regular basis, no less than monthly. The Contractor shall consider provider capabilities for accessing, utilizing and acting on data shared in different formats as well as provider capabilities to share such data internally. The Contractor shall identify and incorporate aligned data sharing approaches and policies with providers to support VBP models, promptly share data, and reduce administrative burden on providers.

2.17.4.4 The Contractor shall fully participate in LDH-directed VBP Workgroups and payment reform initiatives implemented throughout the term of the Contract designed to pay providers for improving quality and efficiency of care and simplifying administration. The Contractor shall enable providers to engage in VBP arrangements that allow the provider to have graduated opportunities for earning performance incentive payments and to obtain interim performance payments pending reconciliation based on the

Contractor's final determination of quality and financial results as applicable to the model.

2.17.4.5 The Contractor's VBP approach shall be designed to align financial incentives for plans and providers and build shared capacity to improve care through data and collaboration.

2.17.4.6 The Contractor shall offer information and tools for providers to query data sets, including information and tools such as:

2.17.4.6.1 Timely and actionable data regarding cost, utilization and quality for attributed Enrollee populations;

2.17.4.6.2 Contact, health screening, and health risk information for attributed Enrollees;

2.17.4.6.3 Identification of high utilizers and other pertinent information;

2.17.4.6.4 Real-time data related to Admission, Discharge, and Transfers; and

2.17.4.6.5 Enrollee registries.

2.17.4.7 The Contractor shall comply with provider profiling and data sharing formats and frequency specifications issued by LDH.

2.17.4.8 The Contractor's data sharing policies and agreements with providers shall address and comply with applicable Federal and State data privacy and security requirements.

2.17.4.9 The Contractor shall employ and clearly identify provider network representatives to support providers that are engaged in VBP arrangements to better understand and act on data to improve quality and manage costs of care.

2.17.4.10 The Contractor shall ensure that it receives Encounter and other data needed under VBP arrangements to meet its obligations under this Contract.

2.17.5 Preferred VBP Arrangements

2.17.5.1 Preferred VBP arrangements are priorities for LDH based on the potential to improve health care and cost-efficiency. The Contractor shall indicate in its VBP Strategic Plan and subsequent updates to the Plan which of the following preferred VBP arrangements it intends to implement and when it will implement such arrangements during the Contract period:

2.17.5.1.1 Maternity-focused VBP arrangements;

2.17.5.1.2 Models supporting physical and behavioral health integration;

2.17.5.1.3 Patient-centered medical home models that are part of a broader payment model that includes Category 2C, 3, or 4 APMs and which support the integration of behavioral health, SDOH, and/or populations with special health care needs;

2.17.5.1.4 Hospital VBP arrangements; and

2.17.5.1.5 Other models as identified by LDH, including, but not limited to, VBP models specifically designed to reduce health disparities and improve equity.

2.17.6 Enrollee Attribution in VBP Arrangements

2.17.6.1 VBP models involve Enrollees being clearly attributed to providers for consideration of quality performance, and in some cases, total cost of care performance of the provider's attributed population, as defined in the VBP model and payment arrangements. The Contractor shall develop and share its Attribution approach for VBP arrangements with LDH and Network Providers in a transparent and accessible manner.

2.17.6.2 The Contractor shall collaborate with providers engaged in VBP models to develop and maintain an accurate, up-to-date list of attributed Enrollees and associated providers. At least monthly, the Contractor shall share complete lists of attributed Enrollees with VBP providers. At a minimum, the Contractor shall share performance and Claims data for attributed Enrollees with VBP providers on a quarterly basis.

2.17.6.3 For a VBP arrangement that includes primary care, the Contractor shall attribute Enrollees to the same provider which has been selected, either by choice or assignment, as the Enrollee's PCP. The Contractor shall educate providers on how to access, utilize, and share data on attributed Enrollees.

2.17.7 Mechanisms for Providers to Dispute Enrollee Attribution

2.17.7.1 The Contractor shall have a process by which a provider may dispute the Contractor's Attribution of an Enrollee in relation to a VBP arrangement as it relates to the measurement of the provider's quality or financial performance in the model. The Contractor shall inform providers of such dispute process and must respond to and address provider complaints related to Enrollee Attribution within fifteen (15) Calendar Days of receipt.

2.17.7.2 For Attribution to PCPs, the Contractor shall attribute Enrollees to their assigned PCP.

2.17.7.3 The Contractor shall consider altering its Attribution and related PCP assignment when an Enrollee is regularly seeing a different provider for primary care services than the PCP to which the Enrollee has been attributed and when an Enrollee has not seen the attributed PCP in the past twelve (12) months.

2.17.7.4 The Contractor shall have clear methods for adjusting its PCP assignment and VBP Attribution methodologies based on data analysis, and shall implement any LDH-directed PCP assignment and Attribution policies and methodologies to ensure uniformity across MCOs.

2.17.8 Financial Benchmarks, Shared Savings Calculations, and Risk Mitigation

2.17.8.1 The Contractor's financial benchmarks in VBP models shall incentivize high-quality, efficient care, enable accountability, and establish targets that fairly reward provider organizations. As part of its VBP agreements, the Contractor shall not hold providers accountable for meeting a higher target for the incentive-based measure than the target to which LDH holds the Contractor for the same measure unless the provider is already performing above the benchmark set by LDH for Contractor performance on the incentive-based measure.

2.17.8.2 The Contractor shall risk-adjust provider payment rates when feasible and appropriate in VBP models to reflect the risk of the attributed population.

2.17.8.3 The Contractor shall transparently communicate to providers the shared savings and risk-sharing parameters involved in participating in a VBP model, such that providers can access the information they need to fully comprehend the opportunities and risks associated with participation. The Contractor shall clearly articulate when and how it will determine provider financial performance and how it will set the targets.

2.17.8.4 The Contractor shall offer providers in good standing and with prior VBP experience with the Contractor the option to obtain a portion of anticipated VBP payments prospectively based on interim financial and quality performance results rather than waiting for potential payments from shared savings calculations after the end of the performance period.

2.17.8.5 The Contractor shall offer providers an audit or appeal process on VBP budget and shared savings or shared risk calculations.

2.17.8.6 For shared risk arrangements, the Contractor shall consider whether and how to use stop-loss or other risk protections in consultation with Network Providers, and consider provider size, financial stability, the potential for random variation in medical expenditures of a population, and a provider's VBP experience. The Contractor shall share financial modeling data with providers to demonstrate potential changes in provider payments prior to accepting downside risk arrangements.

2.18 Claims Management

The Contractor shall ensure that all provider Claims are processed appropriately in accordance with this Contract and the System Companion Guide. The Contractor may be subject to Monetary Penalties if LDH determines, at its sole discretion, that the Contractor has inappropriately

processed provider Claims for services. The obligations outlined in this section shall survive the termination of the Contract for as long as any outstanding obligations under the Contract remain.

2.18.1 Functionality

2.18.1.1 The Contractor shall maintain an electronic Claims management system that shall:

2.18.1.1.1 Uniquely identify the attending and billing provider of each service;

2.18.1.1.2 Identify the date of receipt of the Claim by the Contractor as indicated by the date stamp on the Claim;

2.18.1.1.3 Identify real-time accurate history with dates of adjudication results of each Claim such as paid, denied, pended, adjusted, voided, appealed, etc., and follow up information on disputed Claims;

2.18.1.1.4 Identify the date of payment as indicated on the check or other form of payment, and the number of the check or electronic funds transfer (EFT);

2.18.1.1.5 Identify all data elements as required by LDH for submission of Encounter Data as specified in this Contract and the **MCO System Companion Guide**;

2.18.1.1.6 Accept submission of paper-based Claims and electronic Claims by Network Providers, and Out-of-Network Providers;

2.18.1.1.7 Accept submission of paper-based and electronic adjustments and void transactions;

2.18.1.1.8 Have capability to pay Claims at $0.00; and

2.18.1.1.9 For the purpose of this Section, identify means to capture, edit, and retain.

2.18.1.2 The Contractor shall not derive financial gain from a provider's use of electronic Claims filing functionality and/or services offered by the Contractor or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees and/or charges.

2.18.1.3 The Contractor shall assume all costs associated with Claims processing, including costs for processing and/or reprocessing Encounters, due to errors caused by the Contractor, or due to systems within the Contractor's Span of Control.

2.18.1.4 The Contractor shall provide online and phone-based capabilities to providers to obtain Claim processing status information.

2.18.1.5 The Contractor shall support a CAQH/CORE compliant interface to the automated clearinghouse (ACH) that allows providers to request and receive electronic funds transfer (EFT) of Claims payments.

2.18.1.6 The Contractor shall have procedures, which shall be submitted and approved by LDH in writing prior to implementation, available to providers in written and web form for the acceptance of Claim submissions which include:

2.18.1.6.1 The process for documenting the date of actual receipt of non-electronic Claims and date and time of receipt of electronic Claims;

2.18.1.6.2 The process for reviewing Claims for accuracy and acceptability in accordance with 42 CFR §438.242(b)(3);

2.18.1.6.3 The process for prevention of loss of such Claims; and

2.18.1.6.4 The process for reviewing Claims for determination as to whether Claims are accepted as Clean Claims.

2.18.1.7 The Contractor shall not employ off-system or gross adjustments when processing corrections for payment errors, unless the Contractor requests and receives prior written approval from LDH.

2.18.1.8 For purposes of network management, the Contractor shall notify all Network Providers to file Claims associated with MCO Covered Services for its Enrollees directly with the Contractor.

2.18.1.9 The Contractor shall modify its Claims billing and processing procedures to be consistent with industry norms within thirty (30) Calendar Days of receipt of a request from LDH.

2.18.2 Claims Processing

2.18.2.1 The Contractor shall ensure that all provider Claims are processed according to the following timeframes:

2.18.2.1.1 Within five (5) Business Days of receipt of a Claim, the Contractor shall perform an initial screening, and either reject the Claim, or assign a unique control number and enter it into the system for processing and adjudication;

2.18.2.1.2 Process and pay or deny, as appropriate, at least ninety percent (90%) of all Clean Claims for each Claim type, within fifteen (15) Calendar Days of the date of receipt;

2.18.2.1.3 Process and pay or deny, as appropriate, one hundred percent (100%) of Clean Claims for each Claim type, within thirty (30) Calendar Days of the date of receipt; and

2.18.2.1.4 Pay or deny one hundred percent (100%) of Pended Claims within sixty (60) Calendar Days of the date of receipt.

2.18.2.2 The Contractor may pend Claims submitted by providers that are the subject of a payment suspension due to a credible allegation of Fraud in accordance with 42 CFR §455.23 for the duration of the payment

suspension. Once the suspension period has ended, the Contractor shall Adjudicate any previously Pended Claims in accordance with the timeframes above.

2.18.2.3 The Contractor shall not automatically adjust, down-code, or pay Claims at a lower level of service than what was submitted by the provider.

2.18.2.4 In accordance with 42 CFR § 455.440, all Claims for payment for items and services that were ordered or referred shall contain the National Provider Identifier (NPI) of the provider who ordered or referred such items or services.

2.18.3 Rejected Claims

2.18.3.1 The Contractor may reject Claims because of missing or incomplete information required for adjudication. Paper Claims that are received by the Contractor that are screened and rejected prior to scanning shall be returned to the provider with a letter notifying them of the rejection. Paper Claims received by the Contractor that are scanned prior to screening and then rejected are not required to accompany the rejection letter.

2.18.3.2 The Contractor shall not include a rejected Claim on the Remittance Advice (RA) because it will not have entered the Claims processing system (except for pharmacy RAs).

2.18.3.3 In the Claims rejection letter, the Contractor shall indicate why the Claim is being returned, including all defects or reasons known at the time the determination is made and at a minimum, must include the following:

2.18.3.3.1 The date the letter was generated;

2.18.3.3.2 The Enrollee's name;

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

2.18.3.3.4 The date of each service;

2.18.3.3.5 The patient account number assigned by the provider;

2.18.3.3.6 The total billed charges;

2.18.3.3.7 The date the Claim was received; and

2.18.3.3.8 The reasons for rejection.

2.18.4 Pended Claims

If a Claim is received, but additional information is required for adjudication, the Contractor may pend the Claim and request in writing all necessary information in order for the Claim to be Adjudicated within the timeframes set forth herein. Claims should not be pended solely based on predictive modeling algorithm tools.

2.18.5 Payment to Providers

2.18.5.1.1 At a minimum, the Contractor shall run one (1) provider payment cycle per week, on the same day each week.

2.18.5.2 The Contractor shall encourage that Network Providers, as an alternative to the filing of paper-based Claims, submit and receive Claims information through electronic data interchange (EDI).

2.18.5.3 The Contractor shall pay providers interest at a rate of twelve percent (12%) per annum, calculated daily for the full period in which a payable clean Claim remains unpaid beyond the thirty (30) Calendar Day clean Claims processing deadline. Interest owed to the provider shall be paid the same date that the Claim is Adjudicated. Any interest payment should be reported on the applicable Encounter submissions to the FI as defined in the **MCO System Companion Guide**.

2.18.5.4 The Contractor shall notify providers and LDH within five (5) Business Days of discovery of a system error or "glitch" that impacts reimbursement.

2.18.5.4.1 The notification must outline the process of resolution, including time frames, and be posted on the provider portal on the Contractor's web page and sent to providers via email and/or fax blast.

2.18.5.4.2 The Contractor should provide its provider call center staff with the relevant information immediately after discovery of the system error or "glitch" in order to ensure that staff will be able to properly answer provider questions.

2.18.6 Claims Reprocessing

If the Contractor or LDH or its Subcontractors or Providers discover errors made by the Contractor when a Claim was Adjudicated, the Contractor shall make corrections and reprocess the Claim within fifteen (15) Calendar Days of discovery or notification, or if circumstances exist that prevent the Contractor from meeting this time frame, by a specified date subject to LDH written approval. The Contractor shall pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable Clean Claim remains unpaid beyond the thirty (30) Calendar Day Clean Claims processing deadline. Interest owed to the provider shall be paid on the same date that the Claim is Adjudicated and by either the fifteen (15) Calendar Day Claims reprocessing deadline or the specified deadline approved by LDH in writing, whichever is later. The Contractor shall automatically recycle all impacted Claims for all providers and shall not require the provider to resubmit the impacted Claims.

2.18.7 Adjustments and Voids

The Contractor may adjust or void incorrect Claims payments in accordance with the **MCO Manual**.

2.18.8 Timely Filing Guidelines

2.18.8.1 The Contractor shall require providers to file Louisiana Medicaid Program-only Claims within three hundred sixty-five (365) Calendar Days of the date of service.

2.18.8.2 Electronic submission of pharmacy Claims (reversals and resubmittals) shall be allowed to process electronically within three hundred sixty-five (365) Calendar Days of the date of service.

2.18.8.3 The Contractor shall require Network Providers to file Claims involving third party liability (excluding Medicare) within three hundred sixty-five (365) Calendar Days from the date of service.

2.18.8.4 When Medicare is the primary insurer, the Contractor shall require Network Providers to file the Claim within one hundred eighty (180) Calendar Days from Medicare's EOB of payment or denial.

2.18.8.5 LDH will identify and address any exceptions to these provisions in the **MCO Manual**.

2.18.9 Claim System Edits

2.18.9.1 The Contractor shall perform system edits including, but not limited to:

2.18.9.1.1 Confirming eligibility on each Enrollee;

2.18.9.1.2 Validating Enrollee name;

2.18.9.1.3 Validating unique Enrollee identification number;

2.18.9.1.4 Validating date of service – Perform system edits for valid dates of service, and ensure that dates of services are valid dates, e.g., not dates in the future or outside of an Enrollee's Louisiana Medicaid Program eligibility span;

2.18.9.1.5 Determination of medical necessity – By a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating Claims for medical necessity;

2.18.9.1.6 Covered Services – Ensure that the system verifies that a service is an MCO Covered Service and is eligible for payment;

2.18.9.1.7 Prior Authorization – The system shall determine whether an MCO Covered Service required Prior Authorization and if so, whether the Contractor granted such authorization;

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

2.18.9.1.9 Provider Validation – Ensure that the system shall approve for payment only those Claims received from qualified providers eligible to render the service for which the Claim was submitted and that the provider has not been excluded from receiving Medicaid payments as stipulated in the *Provider Network, Contracts, and Related Responsibilities* section; and

2.18.9.1.10 Quantity of Service – Ensure that the system shall evaluate Claims for services provided to ensure that any applicable benefit limits are applied.

2.18.9.2 The Contractor shall perform post-payment review on a statistically valid sample of Claims to ensure services provided were medically necessary.

2.18.9.3 The Contractor shall have the ability to update national standard code sets such as CPT/HCPCS, ICD-10-CM, and move to future versions as required by CMS or LDH. Updates to code sets are to be complete no later than thirty (30) Calendar Days after notification of inclusion on LDH fee schedule, unless otherwise directed by LDH in writing. This includes annual and other fee schedule updates.

2.18.9.4 Except as otherwise specified by LDH in writing, the Contractor shall use only national standard code sets such as CPT/HCPCS, ICD-10-CM, etc. The Contractor shall also comply with deadlines for communication, testing and implementation of code sets established by CMS and/or LDH.

2.18.9.5 The Contractor shall notify LDH and providers as to when system updates will be in production and of the Contractor's process for the recycling of all impacted Claims, including Denied Claims, that are due to system updates. The recycling of all impacted Claims shall be completed no later than fifteen (15) Calendar Days after the system update.

2.18.9.6 In addition to CPT, ICD-10-CM, ICD-10-PCS and other national coding standards, the Contractor shall use applicable HCPCS Level II and Category II CPT codes to aid both the Contractor and LDH in evaluating performance measures.

2.18.9.7 The Contractor shall perform internal audit reviews at least annually to confirm Claim edits are functioning properly and provide LDH with confirmation of this process. LDH shall be provided the results of internal audit reviews upon request.

2.18.9.8 The Contractor shall employ CMS mandated edits for Louisiana Medicaid Program and nationally recognized clinical editing standards as outlined below:

2.18.9.8.1 At a minimum, these edits shall be maintained and updated annually unless otherwise appropriate and apply to practitioners, outpatient hospitals, and DME services.

2.18.9.8.2 Edits shall be based on current industry benchmarks and best practices including, but not limited to, specialty society criteria, American Medical Association CPT coding guidelines, and CMS mandated edits for Louisiana Medicaid Program, which include the quarterly National Correct Coding Initiative (NCCI) edits or its successor.

2.18.9.8.3 These edits include, but are not limited to, units of service, unbundling, mutually exclusive and incidental procedures, pre/post-op surgical periods, modifier usage, multiple surgery reduction, add-on codes, cosmetic, and assistant surgeon. Editing shall include the ability to apply edits to the current Claim as well as paid history Claims when applicable.

2.18.9.8.4 The Contractor shall provide a written attestation to LDH annually stating that they are adhering to these requirements and are subject to periodic requests from LDH for validation of the edits.

2.18.9.9 The Contractor shall implement CMS mandated edits and NCCI edits quarterly as directed by CMS and adhere to LDH timelines for the updates

2.18.10 Remittance Advices

In conjunction with its payment cycles, the Contractor shall provide that:

2.18.10.1 Each remittance advice generated by the Contractor to a provider shall comply with the provisions of La. R.S. 46:460.71.

2.18.10.2 Adjustments and Voids shall appear on the remittance advice under "Adjusted or Voided Claims" either as Approved or Denied.

2.18.10.3 In accordance with 42 CFR §455.18 and §455.19, the following statements shall be included on each remittance advice sent to providers:

2.18.10.3.1 "This is to certify that the foregoing information is true, accurate, and complete."

2.18.10.3.2 "I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws."

2.18.10.4 Pharmacy remittance advice from the PBM must be issued as a standalone remittance advice, specific to the Louisiana Medicaid Program and separate from other lines of business at the request of the pharmacy.

2.18.10.5 Pharmacy remittance advice shall be submitted in compliance with La. R.S. 22:1856(C), 22:1856(D), and 22:1856(E).

2.18.10.6 The Contractor shall submit a sample of remittance advices that were sent to independent, chain and specialty pharmacies by the PBM to LDH pharmacy staff quarterly. This sample shall include at least ten (10) remittance advices from different pharmacies from each pharmacy type (independent, chain, and specialty). Each quarter shall have samples from different pharmacies.

2.18.11 Sampling of Paid Claims

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

2.18.11.1.1 Description of the service furnished;

2.18.11.1.2 The name of the provider furnishing the service;

2.18.11.1.3 The date on which the service was furnished;

2.18.11.1.4 The amount of the payment made for the service; and

2.18.11.1.5 The method for notifying the Contractor of services not rendered.

2.18.11.2 The Contractor shall stratify the paid Claims sample to ensure that all provider types (or specialties) and all Claim types are proportionally represented in the sample pool from the entire range of services available under the Contract. To the extent that the Contractor or LDH considers a particular specialty (or provider) to warrant closer scrutiny, the Contractor may over sample the group. The paid Claims sample shall be a minimum of two percent (2%) of paid Claims per month to be reported to LDH on a quarterly basis.

2.18.11.3 The notices may be provided by mail, telephonically, or in person (e.g., case management on-site visits).

2.18.11.4 The Contractor shall track any responses received from Enrollees and resolve the responses according to its established policies and procedures. The resolution may be effected through member education, provider education, payment recovery, or referral to LDH. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.

2.18.11.5 Within three (3) Business Days of receipt of a response from an Enrollee, results indicating that paid services may not have been received shall be referred to the Contractor's Fraud and Abuse department for review and to the LDH Program Integrity contact.

2.18.11.6 Reporting shall include, at a minimum, the total number of notices sent to Enrollees, total number of services sent for validation, total number of responses completed, total services requested for validation, number of services validated, analysis of interventions related to resolution, and number of responses referred to LDH for further review.

2.18.12 Claims Dispute Management

2.18.12.1 The Contractor shall develop an internal Claims dispute process for those Claims or group of Claims that have been denied or underpaid. The process shall be submitted as part of Readiness Review to LDH or its designee for approval.

2.18.12.2 The Contractor's Claims Dispute process shall allow providers the option to request binding arbitration for Claims that have denied or underpaid Claims or a group of Claims bundled. Arbitration conducted pursuant to this Section shall be binding on all parties. All costs of arbitration, not including attorney fees, shall be shared equally by the parties.

2.18.12.3 The Contractor shall systematically capture the status and resolution of all Claim disputes as well as all associated documentation.

2.18.12.4 The Contractor shall Adjudicate all disputed Claims to a paid or denied status within thirty (30) Business Days of receipt of the disputed Claim.

2.18.12.5 The provider shall have one hundred eighty (180) Calendar Days from the date of denial to dispute the Denied Claim.

2.18.13 Payment Recoupments

2.18.13.1 The Contractor shall provide written prior notification to a provider of its intent to recoup any payment.

2.18.13.2 The notification shall include:

2.18.13.2.1 The Enrollee's name, date of birth, and Medicaid identification number;

2.18.13.2.2 The date(s) of health care services rendered;

2.18.13.2.3 A complete listing of the specific Claims and amounts subject to the recoupment;

2.18.13.2.4 The specific reasons for making the recoupment for each of the Claims subject to the recoupment;

2.18.13.2.5 The date the recoupment is proposed to be executed;

2.18.13.2.6 The mailing address or electronic mail address where a provider may submit a written response;

2.18.13.2.7 When applicable, the date LDH notified the Contractor of the Enrollee's Disenrollment via the ASC X12N 834 Benefit Enrollment and Maintenance electronic transaction file; and

2.18.13.2.8 When applicable, the effective date of Disenrollment.

2.18.13.3 Before the recoupment is executed, the provider shall have sixty (60) Calendar Days from receipt of written notification of recoupment to submit a written response to the Contractor as to why the recoupment

should not be put into effect on the date specified in the notice. If the provider fails to submit a written response within the time period provided, the Contractor may execute the recoupment on the date specified in the notice.

2.18.13.4 Upon receipt by the Contractor of a written response as to why the recoupment should not be put into effect, the Contractor shall, within thirty (30) Calendar Days from the date the written response is received, consider the statement, including any pertinent additional information submitted by the provider or otherwise available to the Contractor, determine whether the facts justify recoupment, and provide a written notice of determination to each written response that includes the rationale for the determination.

2.18.13.5 If the Contractor determines that the recoupment is valid, the provider shall remit the amount to the Contractor or permit the Contractor to deduct the amount from future payments due to the provider.

2.18.13.6 LDH reserves the right to review and prohibit any recoupment.

2.18.13.7 The Contractor must complete all reviews and/or audits of a provider Claim no later than one (1) year after receipt of a Clean Claim, regardless of whether the provider participates in the Contractor's network. This includes an "automated" review, which is one for which an analysis of the paid Claim is sufficient to determine the existence of an overpayment, whereas no additional documentation is required to be submitted from the provider to determine the existence of an overpayment.

2.18.13.7.1 This limitation does not apply in cases of provider Fraud, Waste, or Abuse that the Contractor did not discover within the one- (1)-year period following receipt of a Claim via "complex" review. (Additional information regarding automated and complex reviews may be found in the *Fraud, Waste, and Abuse Prevention* section.)

2.18.13.7.2 This limitation also does not apply when CMS, OIG, HHS, LLA, the Louisiana Department of Justice, the Government Accountability Office (GAO), LDH, and/or any of their designees conclude an examination, audit, or inspection of a provider more than one (1) year after the Contractor received the Claim.

2.18.13.8 For Enrollees disenrolled due to the invalidation of a duplicate Medicaid ID, the Contractor shall not recover Claim payments under the retroactively dis-enrolled Enrollee's ID if the remaining, valid ID is also linked to the same Contractor for the retroactive Disenrollment period. The Contractor shall identify these duplicate Medicaid IDs for a single Enrollee and resolve the duplication so that histories of the duplicate records are linked or merged.

2.18.13.9 The Contractor shall develop and implement a safeguard for automated reviews to prevent subsequent reviews on a Claim when the denial or

exception reason is the same as a previous denial or exception reason. The Contractor and its Subcontractors shall not recover from a provider via automated review for a Claim for which an automated denial was reversed subsequent to provider dispute, when the denials are for the same reason. For such Claims, the Contractor shall ensure a complex review and consideration of the Claim history or audit trail.

2.18.13.10 At the provider's request, the Contractor shall provide an independent review of Claims that are the subject of an adverse determination by the Contractor. The review shall be provided and conducted in accordance with La. R.S. 46:460.81 through 460.90.

2.18.13.11 The Contractor shall not recoup simply on the basis of an Encounter being denied.

2.18.14 Claims Payment Accuracy Report

2.18.14.1 On a monthly basis, the Contractor shall submit a Claims payment accuracy percentage report to LDH. The report shall be based on an audit conducted by the Contractor. The audit shall be conducted by an entity or staff independent of Claims management, and shall utilize a randomly selected sample of all processed and paid Claims upon initial submission in each month. A minimum sample consisting of two hundred (200) to two hundred-fifty (250) Claims per month, based on financial stratification, shall be selected from the entire population of electronic and paper Claims processed or paid upon initial submission.

2.18.14.2 The minimum attributes to be tested for each Claim selected shall include:

2.18.14.2.1 Claim data is correctly entered into the Claims processing system;

2.18.14.2.2 Claim is associated with the correct provider;

2.18.14.2.3 Proper authorization was obtained for the service;

2.18.14.2.4 Enrollee eligibility at processing date was correctly applied;

2.18.14.2.5 Allowed payment amount agrees with contracted rate;

2.18.14.2.6 Duplicate payment of the same Claim has not occurred;

2.18.14.2.7 Denial reason is applied appropriately;

2.18.14.2.8 Co-payments are considered and applied, if applicable;

2.18.14.2.9 Effect of modifier codes were correctly applied; and

2.18.14.2.10 Proper coding.

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

2.18.14.3.1 Results for each attribute tested for each Claim selected;

2.18.14.3.2 Amount of overpayment or underpayment for each Claim processed or paid in error;

2.18.14.3.3 Explanation of the erroneous processing for each Claim processed or paid in error;

2.18.14.3.4 Determination if the error is the result of a keying error or the result of error in the configuration or table maintenance of the Claims processing system; and

2.18.14.3.5 Claims processed or paid in error have been corrected.

2.18.14.4 If the Contractor subcontracted for the provision of any MCO Covered Services, and the Subcontractor is responsible for processing Claims, then the Contractor shall submit a Claims payment accuracy percentage report for the Claims processed by the Subcontractor.

2.18.15 Encounter Data

2.18.15.1 The Contractor's system shall be able to transmit to and receive electronic data from the FI's system as required for the appropriate submission of Encounter Data.

2.18.15.2 The Contractor shall create a unique Processor Control Number (PCN) and unique Group number (if a group number is utilized) for the Louisiana Medicaid Program and shall submit the PCN, and group number (if a group number is utilized), and the Bank Identification Number with the Encounter Data submission.

2.18.15.3 For Encounter Data submissions, the Contractor shall:

2.18.15.3.1 Submit complete and accurate Encounter Data at least monthly for all dates of service during the term of this Contract to LDH or the FI, as directed by LDH; and

2.18.15.3.2 Submit the Encounter Data in accordance with the Encounter reconciliation schedule published by LDH or its contracted review organization, including Encounters reflecting a zero dollar amount ($0.00) and Encounters in which the Contractor or its Subcontractor has a capitation arrangement with a provider. If the Contractor or its subcontracted vendor(s), individually or in aggregate, fails to submit complete Encounter Data as measured by a comparison of Encounters to cash disbursements within a two-percent (2%) error threshold (i.e., Encounters are at least ninety-eight percent [98%] but no greater than one hundred percent [100%] of cash disbursements), LDH may impose Monetary Penalties in accordance with Attachment G, *Table of Monetary Penalties*. LDH, at its sole discretion, may waive the penalty if Encounters processed by subcontracted vendors (e.g., pharmacy, non-emergency transportation, vision) fall below the completion threshold during the transition to a new vendor; however, this grace period shall not exceed ninety (90) Calendar Days for Encounters processed by either the exiting vendor or the new vendor.

2.18.15.4 The Contractor shall submit HIPAA compliant 837 Encounters for Institutional, Professional and Dental, and the NCPDP D.0 format in a batch processing method for pharmacy Encounters. The Contractor shall be able to transmit this Encounter Data to the FI thirty (30) Calendar Days after the Operational Start Date. Inpatient Hospital services (Institutional Encounters indicating Facility Type Code of 11, 12, 18, 21 or 86) are Adjudicated at the document level. All other Encounters are Adjudicated at the line level.

2.18.15.5 As part of the Readiness Review, the Contractor's system shall be ready to submit Encounter Data to the FI according to specifications, including data elements and reporting requirements, in the **MCO System Companion Guide**. The Contractor's system shall submit such Encounter Data within thirty (30) Calendar Days of the Operational Start Date. The Contractor shall incur all costs associated with certifying HIPAA transactions readiness through a third party prior to submitting Encounter Data to the FI.

2.18.15.6 The Contractor shall provide the FI with complete and accurate Encounter Data for all levels of health care services provided, including all Claims paid, denied, adjusted or voided directly by the Contractor or indirectly through a Subcontractor, regardless of whether the Subcontractor's agreement has since termed.

2.18.15.7 The Contractor shall have the capability to convert all information that enters its Claims system via hard copy paper Claims to electronic Encounter Data, for submission in the appropriate HIPAA compliant formats to LDH's FI.

2.18.15.8 The Contractor shall ensure that all Encounter Data from a Subcontractor is incorporated into files submitted by the Contractor to the FI. The Contractor shall not submit separate Encounter files from Subcontractors.

2.18.15.9 The Contractor shall ensure the level of detail associated with Encounters from providers with whom the Contractor has a capitation arrangement shall be equivalent to the level of detail associated with Encounters for which the Contractor received and settled a FFS Claim.

2.18.15.10 The Contractor shall utilize the **MCO System Companion Guide** to become familiar with the Claims data elements that shall be included in Encounters. The Contractor shall retain all required data elements in Claims history for the purpose of creating Encounters that are compatible with LDH and the FI's billing requirements.

2.18.15.11 The Contractor shall adhere to Federal and/or LDH payment rules in the definition and treatment of certain data elements, such as units of service that are a standard field in the Encounter Data submissions and will be treated similarly by LDH across all MCOs.

2.18.15.12 The Contractor shall submit paid, denied, adjusted, and voided Claims as Encounters to the FI. LDH shall establish the appropriate identifiers to indicate these Claims as Encounters, as provided in the **MCO System Companion Guide**.

2.18.15.13 The Contractor shall ensure that Encounter files contain settled Claims, adjustments, denials or voids, including, but not limited to, adjustments necessitated by payment errors, processed during that payment cycle, as well as Encounters processed during that payment cycle from providers with whom the Contractor has a capitation arrangement.

2.18.15.14 The FI Encounter process shall utilize a LDH-approved version of the Claims processing system (edits and adjudication) to identify valid and invalid Encounter records from a batch submission by the Contractor. Any submission which contains fatal errors that prevent processing, or that does not satisfy defined threshold error rates, shall be rejected and returned to the Contractor for correction and resubmission to the FI in the next payment cycle.

2.18.15.15 LDH has authorized its FI to edit the Contractor's Encounters using a common set of edit criteria, that might cause denials, and The Contractor should resolve denied Encounters when appropriate. Encounter denial codes shall be deemed "repairable" or "non-repairable". The Contractor is required to be familiar with the FI edit codes and dispositions for the purpose of repairing Encounters denied by the FI. A list of Encounter edit codes is located in the **MCO System Companion Guide.**

2.18.15.16 In order to maintain integrity of processing, the Contractor shall address any issues that prevent processing of an Encounter. The Contractor shall address ninety percent (90%) of reported repairable errors within thirty (30) Calendar Days and one hundred percent (100%) of reported repairable errors within sixty (60) Calendar Days or within a negotiated timeframe approved by LDH in writing. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable Corrective Action Plan, may result in Monetary Penalties.

2.18.15.17 The Contractor CEO, CFO or their designee shall attest to the truthfulness, accuracy, and completeness of all Encounter Data submitted.

2.18.15.18 The Contractor shall make an adjustment to Encounters when the Contractor discovers the data is incorrect, no longer valid, or some element of the Claim not identified as part of the original Claim needs to be changed except as noted otherwise. Incorrect provider numbers, incorrect Enrollee Medicaid ID numbers, or incorrect Claim types cannot

be adjusted. Rather, the Encounter must be voided and resubmitted as an original. All other adjustments to an Encounter shall be done as an adjustment record.

2.18.15.19 Encounters submitted by the Contractor must contain the Claims data submitted to the Contractor by the provider without alterations, except for adjustments required for Claims processing as provided above. To the extent that the provider submits an adjusted Claim to the Contractor to correct missing or incomplete medical information, the Contractor must then submit the corrected Claim to the FI as an Encounter.

2.18.15.20 If LDH or its designee discovers errors or a conflict with a previously Adjudicated Encounter, the Contractor shall be required to adjust or void the Encounter within fourteen (14) Calendar Days of notification by LDH, or if circumstances exist that prevent the Contractor from meeting this time frame, by a specified date approved by LDH in writing. The Contractor shall obtain prior approval from LDH in writing for any submission to the Fiscal Intermediary for numbers greater than one hundred thousand (100,000) Encounters.

2.18.16 Claims Summary Report

The Contractor shall submit monthly Claims Summary Reports of paid and Denied Claims to LDH by Claim type. Instructions are provided in the **MCO System Companion Guide**.

2.18.17 Pharmacy Claims Processing

2.18.17.1 System Requirements

2.18.17.1.1 The Contractor shall have an automated Claims and Encounter processing system for pharmacy Claims that will support the requirements of this Contract and ensure the accurate and Timely processing of Claims and Encounters. The Contractor shall allow pharmacies to back bill electronically (reversals and resubmissions) for three hundred sixty-five (365) Calendar Days from the date of the original submission of the Claim.

2.18.17.1.2 The Contractor shall support electronic submission of Claims using the most current HIPAA compliant transaction standard.

2.18.17.1.3 Pharmacy Claim edits shall include eligibility, drug coverage, benefit limitations, prescriber and prospective/concurrent drug utilization review edits.

2.18.17.1.4 The system shall provide for an automated update to the National Drug Code file including all product, packaging, prescription and pricing information. The system shall provide online access to reference file information. The system shall maintain a history of the pricing schedules and other significant reference data. The drug file for both retail and specialty drugs, including price, shall be updated within three (3) Business Days of receipt of the drug file.

2.18.17.1.5 The Contractor shall comply with the Claims history requirements in this Section.

2.18.17.1.6 The Contractor shall ensure that the manufacturer number, product number, and package number for the drug dispensed shall be listed on all Claims. This information shall be taken from the actual package from which the drug is usually purchased by a provider, from a supplier whose products are generally available to all pharmacies and reported in one or more national compendia.

2.18.17.1.7 Provisions shall be made to maintain permanent history by service date for those services identified as "once-in-a-lifetime."

2.18.17.2 Pharmacy Rebates

The Contractor shall submit all drug Encounters, with the exception of inpatient hospital drug Encounters, to LDH or its designee pursuant to the requirements of this section. LDH or its designee shall submit these Encounters for Federal or supplemental pharmacy rebates from manufacturers under the authority of the LDH Secretary pursuant to the Section 2501 of the Patient Protection and Affordable Care Act (ACA).

2.18.17.3 Pharmacy Encounters Claims Submission

2.18.17.3.1 The Contractor shall submit a weekly Claim-level detail file of pharmacy Encounters to LDH which includes individual Claim-level detail information on each pharmacy Claim dispensed to an Enrollee including, but not limited to, the total number of metric units, dosage form, strength and package size, and National Drug Code of each covered outpatient drug dispensed to Enrollees. This weekly submission must comply with Encounter Data requirements of this section. See the **MCO System Companion Guide** for a complete listing of Claim fields required.

2.18.17.3.2 At the request of LDH or the FI, the Contractor shall submit pharmacy Claims information in an electronic format that is suited to allow for integration with the State's pharmacy rebate program according to the schedule established by LDH in writing. The pharmacy rebate process is a quarterly process, and Claims information is usually required before the end of the month that follows the end of the quarter.

2.18.17.3.3 The Contractor shall require that Network Providers who are covered entities, as defined by Section 340B of the Public Health Service Act, utilize the same carve-in or carve-out designation for the Contractor's Enrollees as for FFS. If a covered entity appears on the Medicaid Exclusion File, LDH will exclude that provider's FFS and MCO Claims from rebate invoicing. Claims for FFS and Enrollees are treated identically in regards to exclusion from rebate invoicing.

2.18.17.3.4 The Contractor shall utilize a unique Processor Control Number (PCN) and unique Group Number (if a group number is utilized) for the Louisiana Medicaid Program. This PCN and group number (if a group number is utilized) shall be submitted to LDH before processing any pharmacy Claims.

2.18.17.3.5 Contract pharmacies are not permitted to bill the Louisiana Medicaid Program for drugs purchased at 340B pricing. This includes both FFS and the MCOs.

2.18.17.3.6 The Contractor shall include billing instructions on how to identify 340B Claims/Encounters in their contracts with 340B providers.

2.18.17.4 Disputed Pharmacy Encounter Submissions

2.18.17.4.1 At least quarterly, LDH may review the Contractor's pharmacy Encounters and send a file back to the Contractor of disputed Encounters that were identified through the drug rebate invoicing process.

2.18.17.4.2 Within sixty (60) Calendar Days of receipt of the disputed Encounter file from LDH, the Contractor shall, if needed, correct and resubmit any disputed Encounters and send a response file to LDH or its designee that includes 1) corrected and resubmitted Encounters as described in the Rebate Section of the **MCO System Companion Guide**, and/or 2) a detailed explanation of why the disputed Encounters could not be corrected including documentation of all attempts to correct the disputed Encounters at an Encounter level detail, as described in the Rebate Section of the **MCO System Companion Guide**.

2.18.17.4.3 The Contractor may be subject to Monetary Penalties in accordance with Attachment G, *Table of Monetary Penalties*, for failure to submit weekly pharmacy Encounter files and/or a response file to the disputed Encounters file within sixty (60) Calendar Days as detailed above for each disputed Encounter.

2.18.17.5 Use of a Pharmacy Benefits Manager (PBM)

2.18.17.5.1 The Contractor shall utilize a Single PBM designated by LDH for pharmacy Claims payment and administrative services.

2.18.17.5.2 The Contractor shall submit a plan for oversight of the PBM's performance during Readiness Review to LDH or its designee. The plan shall be subject to LDH approval and comply with this Contract and all LDH requirements; and

2.18.17.6 With ninety (90) Calendar Days of written notice to the Contractor, LDH may carve out all outpatient pharmacy services from managed care.

2.18.18 Audit Requirements

The Contractor shall ensure that its systems facilitate the auditing of individual Claims. Adequate audit trails shall be provided throughout the systems. LDH may require the Contractor and/or Subcontractors, if performing a key internal control, to submit to financial and performance audits from outside companies to ensure both the financial viability of the program and the operational viability, including the policies and procedures placed into operation.

The Contractor shall be responsible for any additional costs incurred by LDH associated with on-site audits or other oversight activities that result when required systems are located outside of the State of Louisiana.

2.18.18.1 State Audits

2.18.18.1.1 The Contractor shall provide to State auditors (including LLA), or their designee, upon written request, files for any specified accounting period that a valid Contract exists in a file format or audit defined media, magnetic tapes, CD or other media compatible with LDH and/or State auditor's facilities. The Contractor shall provide information necessary to assist the State auditors in processing or utilizing the files.

2.18.18.1.2 If the auditor's findings point to discrepancies or errors, the Contractor shall provide a written Corrective Action Plan to LDH within ten (10) Business Days of receipt of the final audit report.

2.18.18.2 Louisiana Legislative Auditor Authority

2.18.18.2.1 The Contractor shall enter into a data sharing agreement (DSA) with LLA to authorize the sharing of data and information.

2.18.18.2.2 The Contractor agrees and acknowledges that the LLA has the authority pursuant to La. R.S. 24:51 et seq., subject to State and Federal laws and privileges protecting the confidentiality of information, to conduct oversight and audit of LDH, including the Managed Care Program. Pursuant to the DSA, LLA may, in coordination with LDH and the Contractor:

2.18.18.2.2.1 Attend meetings between the Contractor, LDH, and MFCU at LDH's request;

2.18.18.2.2.2 Evaluate the effectiveness of the Contractor's program integrity outcomes;

2.18.18.2.2.3 Audit, evaluate and inspect the books, records, and contracts related to the performance of the Contractor; and

2.18.18.2.2.4 Access all audit information relating to the performance of the Contractor obtained by LDH related to the Managed Care Program.

2.18.18.3 Independent Audits of Systems

2.18.18.3.1 The Contractor shall submit an independent SOC 2 Type II system audit. The audit shall review system security, system availability, system confidentiality and processing integrity for the Louisiana Medicaid Program line of business. The audit period shall be twelve (12) consecutive months, aligning with the Contractor's fiscal year, with no breaks between subsequent audit periods.

2.18.18.3.2 The Contractor shall supply LDH with an exact copy of the SOC 2 Type II independent audit no later than six (6) months after the close of the Contractor's fiscal year.

2.18.18.3.3 The Contractor shall deliver to LDH a Corrective Action Plan to address deficiencies identified during the audit within thirty (30) Business Days of the Contractor's receipt of the final audit report.

2.18.18.3.4 These audit requirements are also applicable to any Subcontractors or vendors delegated the responsibility of adjudicating Claims on behalf of the Contractor. The cost of the audit shall be borne by the Contractor or Subcontractor.

2.18.18.4 Audit Coordination and Claims Reviews

2.18.18.4.1 The Contractor shall coordinate audits with LDH as directed by LDH.

2.18.18.4.2 LDH reserves the right to review any Claim paid by the Contractor or designee. The Contractor has the right to collect or recoup any overpayments identified by the Contractor from providers of service in accordance with applicable Federal and State laws, regulations, rules, policies, and procedures. If an overpayment is identified by the State or its designee and the provider fails to remit payment to the State, LDH may require the Contractor to collect and remit the overpayment to LDH. Failure by the Contractor to collect from the provider does not relieve the Contractor from remitting the identified overpayment to LDH.

2.18.18.4.3 The Contractor must complete all reviews and/or audits of a provider Claim no later than one (1) year after receipt of a Clean Claim, regardless of whether the provider participates in the Contractor's network. This includes an "automated" review, which is one for which an analysis of the paid Claim is sufficient to determine the existence of an overpayment, whereas no additional documentation is required to be submitted from the provider to determine the existence of an overpayment.

2.18.18.4.3.1 This limitation does not apply in cases of provider Fraud, Waste, or Abuse that the Contractor did not discover within the one (1)-year period following receipt of a Claim via "complex" review. (Additional information regarding automated and complex reviews may be found in the *Fraud, Waste, and Abuse Prevention* section.)

2.18.18.4.3.2 This limitation also does not apply when CMS, OIG, HHS, LLA, the Office of the Attorney General, GAO, LDH, and/or any of their designees conclude an examination, audit, or inspection of a provider more than one (1) year after the Contractor received the Claim.

2.18.19 LaHIPP

2.18.19.1 The Louisiana Health Insurance Premium Payment (LaHIPP) program is a Louisiana Medicaid program that pays all or part of the health insurance premium for an employee and their family if: (a) health insurance is available from their job (i.e., Employer Sponsored Insurance); (b) someone in the family has coverage through the Louisiana Medicaid Program; and (c) it is determined that it would cost less for the Louisiana Medicaid Program to pay the health insurance premium for the person who receives coverage through the Louisiana Medicaid Program than it would be for the Louisiana Medicaid Program to pay the cost of the same

Enrollee's per member per month payment for physical health coverage through the Enrollee's MCO. The goal of LaHIPP is to reduce the number of uninsured Louisiana citizens and lower Louisiana Medicaid Program spending by establishing a third party resource as the primary payer of the Enrollee's medical expenses.

2.18.19.2 LDH is responsible for determining if an individual qualifies for LaHIPP participation. LaHIPP is not an eligibility category. LaHIPP participants are identified in the TPL file.

2.18.19.3 LDH is responsible for issuing payment for all or part of LaHIPP participants' health insurance premium.

2.18.19.4 All LaHIPP participants are mandatorily enrolled in the Managed Care Program for SBHS and NEMT, including NEAT, unless residing in an institution as specified under Section 2.3.

2.18.19.5 The Contractor is responsible for payment of LaHIPP participants' total member liability (co-payments, co-insurance and deductibles) if the participant uses a provider that accepts the insurance as primary payer and the Louisiana Medicaid Program as secondary payer. If the provider does not accept this payment arrangement, the participant shall be responsible for the member liability. The Contractor pays only after the third party has met the legal obligation to pay. The Contractor is always the payer of last resort, except when the Contractor is responsible for payment as primary payer for Medicaid Covered Services not covered by commercial insurance as primary payer (e.g., mental health and transportation services).

2.18.19.6 The services listed below are typically not reimbursed by commercial health plans. The Contractor shall accept the following Claims billed directly from the provider without requiring an explanation of benefits from the primary carrier and pay as primary payer:

2.18.19.6.1 H0018-Therapeutic Group Home;

2.18.19.6.2 H0039-Assertive Community Treatment per diem;

2.18.19.6.3 H0045-Crisis Stabilization;

2.18.19.6.4 H2017-Psychosocial Rehabilitation Services;

2.18.19.6.5 H0036-Community psychiatric support and treatment;

2.18.19.6.6 H2033-Multi-systemic Therapy;

2.18.19.6.7 H2011-Crisis Intervention Service, per fifteen (15) minutes;

2.18.19.6.8 S9484-Behavioral Health Crisis Care;

2.18.19.6.9 S9485-Crisis Intervention Mental Health Services;

2.18.19.6.10 T1019-Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Personal Care Services (PCS); and

2.18.19.6.11 T1025, T1026, T2002-Pediatric Day Health Care.

2.19 Systems and Technical Requirements

2.19.1 General Requirements

2.19.1.1 The Contractor shall maintain an automated Management Information System (MIS), hereinafter referred to as System, which accepts and processes provider Claims, verifies eligibility, collects and reports Encounter Data, and validates Prior Authorization and pre-certification that complies with LDH and Federal reporting requirements. The Contractor shall ensure that its System meets the requirements of the Contract, the **MCO Manual**, and all applicable Federal and State laws, regulations, rules, and policies, including, but not limited to, Medicaid confidentiality, HIPAA, and American Recovery and Reinvestment Act (ARRA) privacy and security requirements.

2.19.1.2 The System shall provide information on areas including, but not limited to, utilization, Claims, Grievances and Appeals, and Disenrollment for reasons other than loss of Louisiana Medicaid Program eligibility [42 CFR §438.242(a)].

2.19.1.3 The Contractor shall comply with Section 6504(a) of the **PPACA**, which requires that State Claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized Claims processing and information retrieval systems in operation by the State to meet the requirements of Section 1903(r)(1)(F) of the Act [42 CFR §438.242(b)(1); Section 6504(a) of the ACA; Section 1903(r)(1)(F) of the Act].

2.19.1.4 The Contractor's application systems foundation shall employ a relational data model in its database architecture, which would entail the utilization of a relational database management system (RDBMS). The Contractor's application systems shall support query access using Structured Query Language (SQL). Other standard connector technologies, such as Open Database Connectivity (ODBC) and/or Object Linking and Embedding (OLE), are desirable.

2.19.1.5 The Contractor shall comply with the health IT standards referenced in 45 CFR Part 170, Subpart B and the Interoperability Standards Advisory (ISA) as set forth by the Office of the National Coordinator for Health IT (ONC).

2.19.1.6 The Contractor 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**.

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

2.19.1.8 If the Contractor uses different Management Systems for physical health services and behavioral health services, these systems shall be interoperable. In addition, the Contractor shall have the capability to integrate data from the different systems.

2.19.1.9 The Contractor's System shall have, and maintain, capacity sufficient to handle the workload projected for the Operational Start Date and shall be scalable and flexible so that it can be adapted as needed, within negotiated timeframes, in response to changes in the Contract requirements.

2.19.1.10 The Contractor shall be capable of transmitting all data, which is relevant for analytical purposes, to LDH on a regular schedule in XML format. Final determination of relevant data will be made by LDH based on collaboration between both parties. The schedule for transmission of the data will be established by LDH and dependent on the needs of LDH related to the data being transmitted. XML files for this purpose shall be transmitted via Secure File Transfer Protocol (SFTP) to LDH. Any other data or method of transmission used for this purpose shall be via written agreement by both parties.

2.19.1.11 The Contractor is responsible for procuring and maintaining hardware and software resources which are sufficient to successfully perform the services detailed in this Contract.

2.19.1.12 The Contractor shall adhere to Federal and State laws, regulations, rules, policies, procedures, and guidelines as well as industry standards and best practices for systems or functions required to support the requirements of this Contract.

2.19.1.13 Unless explicitly stated to the contrary, the Contractor is responsible for all expenses required to obtain access to LDH systems—including systems maintained by other State contractors including, but not limited to, FI and Enrollment Broker resources that are relevant to successful completion of

the requirements of this Contract. The Contractor is also responsible for expenses required for LDH to obtain access to the Contractor's systems or resources which are relevant to the successful completion of the requirements of this Contract. Such expenses are inclusive of hardware, software, network infrastructure and any licensing costs.

2.19.1.14 The Contractor's interface connections with the State shall be established, monitored, and maintained in compliance with the State's Information Security Policy located at: http://www.doa.la.gov/pages/ots/informationsecurity.aspx

2.19.1.15 The Contractor or its designated Subcontractor shall take all steps necessary, as determined by LDH, to ensure that the Contractor's systems are always able to interface with LDH IT applications, including the State's Enterprise Architecture.

2.19.1.16 Any confidential information shall be encrypted to FIPS 140-2 standards when at rest or in transit.

2.19.1.17 Contractor owned resources shall be compliant with industry standard physical and procedural safeguards (NIST SP 800-114, NIST SP 800-66, NIST 800-53A, ISO 17788, etc.) for confidential information (HITECH, HIPAA Part 164).

2.19.1.18 Any Contractor use of flash drives or external hard drives for storage of Louisiana Medicaid Program data shall first receive written approval from LDH and upon such approval shall adhere to FIPS 140-2 hardware level encryption standards.

2.19.1.19 The Contractor shall comply with LDH electronic visit verification (EVV) requirements for personal care services (PCS) and home health care services.

2.19.1.20 All Contractor utilized computers and devices shall:

2.19.1.20.1 Be protected by industry standard virus protection software which is automatically updated on a regular schedule;

2.19.1.20.2 Have installed all security patches which are relevant to the applicable operating system and any other system software; and

2.19.1.20.3 Have encryption protection enabled at the Operating System level.

2.19.1.21 The Contractor shall have:

2.19.1.21.1 Capabilities of interagency electronic transfer to and from the participating State agencies (LDH-OBH, DCFS, and OJJ) as needed to support the operations as determined by LDH;

2.19.1.21.2 Electronic storage and retrieval of individualized Plans of Care (POC), treatment plans, crisis plans, and Advance Directives;

2.19.1.21.3 An MCO Data Warehouse that supports the Timely submission of valid data, including, but not limited to, Encounter Data;

2.19.1.21.4 A secure online web-based portal that allows providers and State agencies (DCFS, LDOE, LDH, and OJJ) to submit and receive responses to referrals and Prior Authorizations for services; and

2.19.1.21.5 An MIS that regularly (e.g., bi-weekly) electronically transfers client/episode-level recipient, assessment, service, and provider data as directed by LDH for purposes of State and Federal reporting (e.g., SAMHSA National Outcome Measures [NOM]S, Treatment Episode Data Sets [TEDS])-, Government Performance Reporting and Results Act [GPRA]), and for ad hoc reporting as needed by the State for service quality monitoring and performance accountability.

2.19.2 HIPAA Standards and Code Sets

2.19.2.1 The Contractor's 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 (SFTP) over a secure connection such as a Virtual Private Network (VPN), that are in use at the start of Systems Readiness Review activities. Data elements and file format requirements may be found in the **MCO System Companion Guide**.

2.19.2.2 All HIPAA-conforming exchanges of data between LDH, its contractors, and the Contractor shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker.

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

2.19.2.3.1 ASC X12N 834 Benefit Enrollment and Maintenance;

2.19.2.3.2 ASC X12N 835 Claims Payment Remittance Advice Transaction;

2.19.2.3.3 ASC X12N 837I Institutional Claim/Encounter Transaction;

2.19.2.3.4 ASC X12N 837P Professional Claim/Encounter Transaction;

2.19.2.3.5 ASC X12N 837D Dental Claim/Encounter Transaction;

2.19.2.3.6 ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;

2.19.2.3.7 ASC X12N 276 Claims Status Inquiry;

2.19.2.3.8 ASC X12N 277 Claims Status Response;

2.19.2.3.9 ASC X12N 278 Utilization Review Inquiry/Response;

2.19.2.3.10 ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products; and

2.19.2.3.11 NCPDP Pharmacy Claims.

2.19.2.4 The Contractor shall not revise or modify standardized forms or formats.

2.19.2.5 Transaction types are subject to change, and the Contractor shall comply with applicable Federal and HIPAA standards and regulations as they occur.

2.19.2.6 The Contractor shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with LDH. These shall include, but not be limited to, HIPAA based standards and Federal safeguard requirements including signature requirements described in the **CMS State Medicaid Manual**.

2.19.3 Connectivity

2.19.3.1 The Contractor shall interface with LDH, the FI, the Enrollment Broker, and their designees. The Contractor shall have capacity for real time connectivity to all LDH approved systems. The Contractor shall have the capability to allow and enable authorized LDH personnel to have real-time connectivity to the Contractor's system as remote connections from LDH offices.

2.19.3.2 The Contractor's System shall conform and adhere to the data and document management standards of LDH and the FI, inclusive of standard transaction code sets as outlined in the **MCO System Companion Guide**.

2.19.3.3 The Contractor's Systems shall utilize mailing address standards in accordance with the United States Postal Service.

2.19.3.4 The Contractor shall encourage all hospitals, physicians, and other providers in its network to adopt certified electronic health record technology (CEHRT) and comply and attest with its corresponding meaningful use requirements and deadlines as outlined by CMS and the Office of the National Coordinator (ONC).

2.19.3.5 The Contractor shall require all EDs in its network to exchange admit discharge transfer (ADT) data with a Health Information Exchange (HIE) ED visit registry to aid in identification of and creation of policies around high utilizers, drug seeking behavior, and Care Management. The visit registry shall consist of three (3) basic attributes: 1) the ability to capture and match patients based on demographics information, 2) the ability to

identify the facility at which care is being sought, and 3) at minimum, the chief complaint of the visit. These three (3) pieces of information are commonly available through the Health Level Seven (HL7) ADT message standard and in use by most ED admission systems in use today across the country. This data shall be available in real-time in order to assist providers and systems with up-to-date information for treating patients appropriately.

2.19.3.6 The Contractor shall require all network hospitals to comply with the data submission requirements of La. R.S. 40:1173.1 through 1173.6, including, but not limited to, syndromic surveillance data under the Sanitary Code of the State of Louisiana (LAC 51:II.105). The Contractor shall encourage the use of HIEs where direct connections to public health reporting information systems are not feasible or are cost prohibitive.

2.19.3.7 All information, whether data or documentation and reports that contain references to that information involving or arising out of the Contract, is owned by LDH. The Contractor is expressly prohibited from sharing or publishing LDH's information and reports without the prior written consent of LDH. In the event of a dispute regarding the sharing or publishing of information and reports, LDH's decision on this matter shall be final.

2.19.3.8 The Medicaid Management Information System (MMIS) processes Claims and payments for Medicaid Covered Services for FFS. LDH shall require the Contractor to comply with all transitional requirements as necessary if LDH contracts with a new FI during the Contract term at no cost to LDH or the FI.

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

2.19.3.10 LDH may require the Contractor to complete an Information Systems Capabilities Assessment (ISCA), which shall be provided by LDH. The ISCA shall be completed and returned to LDH as part of Readiness Review and upon request thereafter.

2.19.4 Hardware and Software

The Contractor shall maintain hardware and software compatible with current LDH requirements in accordance with the **MCO Manual**.

2.19.5 Network and Back-up Capabilities

The Contractor shall have network and back-up capabilities in accordance with the **MCO Manual**.

2.19.6 Resource Availability and Systems Changes

2.19.6.1 Resource Availability

The Contractor shall provide Systems Help Desk services to LDH, its FI, and Enrollment Broker staff that have direct access to the data in the Contractor's Systems.

2.19.6.1.1 The Systems Help Desk shall:

2.19.6.1.1.1 Be available via local and toll-free telephone service and via e-mail on Business Days from 7:00 a.m. to 7:00 p.m., Central Time. Upon request by LDH, the Contractor shall be required to staff the Systems Help Desk on a State-designated holiday, Saturday, or Sunday;

2.19.6.1.1.2 Answer questions regarding the Contractor's System functions and capabilities; report recurring programmatic and operation problems to appropriate staff for follow-up; redirect problems or queries that are not supported by the Systems Help Desk, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate LDH staff;

2.19.6.1.1.3 Ensure individuals who place calls after hours have the option to leave a message. The Contractor's staff shall respond to messages left between the hours of 7:00 p.m. and 7:00 a.m. by noon, Central Time, the next Business Day;

2.19.6.1.1.4 Ensure recurring problems not specific to Systems unavailability identified by the Systems Help Desk are documented and reported to the Contractor's management within one (1) Business Day of recognition so that deficiencies are promptly corrected; and

2.19.6.1.1.5 Have a service management system that provides an automated method to record, track and report all questions and/or problems reported to the Systems Help Desk.

2.19.6.2 Systems Quality Assurance Plan

The Contractor shall ensure that written Systems process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems. The Systems Quality Assurance Plan information systems documentation requirements must be submitted to LDH or its designee as part of Readiness Review for approval. At a minimum, the Systems Quality Assurance Plan must address the following:

2.19.6.2.1 The Contractor shall develop, prepare, print, maintain, produce, and distribute to LDH distinct Systems design and management manuals, user manuals and quick reference guides, and any updates.

2.19.6.2.2 The Contractor shall ensure the Systems user manuals contain information about, and instruction for, using applicable Systems functions and accessing applicable system data.

2.19.6.2.3 The Contractor shall ensure when a System change is subject to LDH prior written approval, the Contractor will submit any necessary revision(s) to the appropriate manuals before implementing said Systems changes.

2.19.6.2.4 The Contractor shall ensure all aforementioned manuals and reference guides are available in printed form and online.

2.19.6.2.5 The Contractor shall update the electronic version of these manuals immediately, and update printed versions within ten (10) Business Days of the update taking effect.

2.19.6.2.6 The Contractor shall provide to LDH documentation describing its Systems Quality Assurance Plan.

2.19.6.3 Systems Changes

2.19.6.3.1 The Contractor's Systems shall conform to future Federal and/or LDH specific standards for Encounter Data exchange prior to the standard's effective date, unless otherwise directed by CMS or LDH.

2.19.6.3.2 If a system update and/or change is necessary, the Contractor shall draft appropriate revisions for the documentation or manuals, and present to LDH thirty (30) Calendar Days prior to implementation, for LDH review and approval. Documentation revisions shall be accomplished electronically and shall be made available for LDH review in an easily accessible, near real-time method. Printed manual revisions shall occur within ten (10) Business Days of the actual revision.

2.19.6.3.3 The Contractor shall notify LDH staff of the following changes to its System within its Span of Control upon the earlier of beginning work on the changes or at least ninety (90) Calendar Days prior to the projected date of the change, unless otherwise directed by LDH:

2.19.6.3.3.1 Major changes, upgrades, modification or updates to application or operating software associated with the following core production functionality:

Claims processing;

Eligibility and Enrollment processing;

Service authorization management;

Provider Enrollment and data management; and

Conversions of core transaction management Systems.

2.19.6.3.4 The Contractor shall respond to LDH notification of System problems not resulting in System unavailability according to the following timeframes:

2.19.6.3.4.1 Within five (5) Calendar Days of receiving notification from LDH, the Contractor shall respond in writing to notices of system problems.

2.19.6.3.4.2 Within fifteen (15) Calendar Days, the correction shall be made or a requirements analysis and specifications document will be due.

2.19.6.3.4.3 The Contractor shall correct the deficiency by an effective date to be determined by LDH.

2.19.6.3.4.4 The Contractor's Systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.

2.19.6.3.4.5 The Contractor shall put in place procedures and measures for safeguarding against unauthorized modification to the Contractor's Systems.

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

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

2.19.7 Systems Refresh Plan

2.19.7.1 The Contractor shall provide to LDH or its designee a Systems Refresh Plan as part of Readiness Review and sixty (60) Calendar Days prior to implementation of revisions. The plan shall outline how Systems within the Contractor's Span of Control shall be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors.

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

2.19.8 Other Electronic Data Exchange

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

2.19.8.2 The Contractor shall implement Optical Character Recognition (OCR) technology that minimizes manual indexing and automates the retrieval of scanned documents.

2.19.9 Electronic Messaging

2.19.9.1 The Contractor shall provide a continuously available electronic mail communication link (e-mail system) to facilitate communication with LDH. This e-mail system shall be capable of attaching and sending documents created using software compatible with LDH's installed version of Microsoft Office (currently 2016) and any subsequent upgrades as adopted. The e-mail system shall also be capable of sending e-mail blasts to providers.

2.19.9.2 As needed, the Contractor shall be able to communicate with LDH over a secure Virtual Private Network (VPN).

2.19.9.3 The Contractor shall comply with national standards for submitting PHI electronically and shall set up a secure emailing system that is password protected for both sending and receiving any PHI.

2.19.10 Eligibility and Enrollment Data Exchange

The Contractor shall:

2.19.10.1 Receive, process and update Enrollment files sent by the Enrollment Broker, and update eligibility and Enrollment databases within the following timelines:

2.19.10.1.1 Daily files – within twenty-four (24) hours of receipt;

2.19.10.1.2 Quarterly or monthly reconciliation files – within five (5) Business Days of receipt; and

2.19.10.1.3 Special corrections files – within seven (7) Business Days of receipt;

2.19.10.2 Be capable of uniquely identifying (i.e., Master Patient Index) a distinct Enrollee across multiple populations and Systems within its Span of Control; and

2.19.10.3 Be able to identify potential duplicate records for a single Enrollee and, upon confirmation of said duplicate record by LDH, resolve the duplication within five (5) Business Days after receipt of manual correction, such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

2.19.11 Provider Enrollment

2.19.11.1 At the onset of the Contract and periodically as changes are necessary, LDH shall furnish to the Contractor a list of Medicaid provider types, specialty, and sub-specialty codes. In order to coordinate provider Enrollment records, the Contractor shall utilize the published list of Medicaid provider types, specialty, and sub-specialty codes in all provider data communications with LDH and the Enrollment Broker. The Contractor shall provide the following:

2.19.11.1.1 A weekly Provider Registry File as described in the **MCO System Companion Guide**;

2.19.11.1.2 A weekly Primary Care Provider Linkage file as described in the **MCO System Companion Guide**; and

2.19.11.1.3 Performance of all Federal or State mandated exclusion background checks on all providers, including owners and managers. The providers shall perform the same for all their employees at least annually.

2.19.12 Information Systems Availability

The Contractor shall:

2.19.12.1 Not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the Contractor's Span of Control;

2.19.12.2 Allow LDH personnel, agents of the Louisiana Attorney General's Office, individuals authorized by LDH in writing, and CMS direct, real-time, read-only access to its data for the purpose of data mining and review. Access shall be granted within thirty (30) Calendar Days of LDH request. Direct, real-time, read-only access can be provided through a SQL based production-like reporting environment to be updated no less than weekly with the ability to query using Microsoft SQL Server Management Studio©, or similar enterprise-grade technology which shall be subject to LDH approval. This reporting environment shall include all data from the systems referenced in the Contract or any additional data upon LDH request.

2.19.12.2.1 Access shall be provided to the following Contractor (including Subcontractors) systems (this is not an exclusive list):

2.19.12.2.1.1 Prior Authorization;

2.19.12.2.1.2 Claims processing;

2.19.12.2.1.3 Provider portal;

2.19.12.2.1.4 Third party liability;

2.19.12.2.1.5 Fraud, Waste, and Abuse;

2.19.12.2.1.6 Pharmacy benefits manager POS;

2.19.12.2.1.7 Pharmacy benefits manager Prior Authorization; and

2.19.12.2.1.8 Provider contracting and credentialing.

2.19.12.2.2 The Contractor's satisfaction of the requirements to provide the direct, real-time access to LDH personnel shall not constitute constructive compliance with nor relieve the Contractor of any duty to satisfy any other provision of this Contract, including, but not limited to, the Contractor's obligation to provide information at the request of LDH.

2.19.12.3 Provide training of LDH staff on how to use the Contractor's Systems and data on-site at the Contractor's location upon request by LDH;

2.19.12.4 Ensure that critical Enrollee and provider internet and/or telephone-based IVR functions and information functions are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week except during periods of scheduled System unavailability agreed upon by LDH and the Contractor. Unavailability caused by events outside of the Contractor's Span of Control is outside of the scope of this requirement;

2.19.12.5 Ensure that, at a minimum, all other System functions and information are available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m., Central Time, Monday through Friday;

2.19.12.6 Ensure that the systems and processes within its Span of Control associated with its data exchanges with the FI and/or Enrollment Broker, and their designees are available and operational;

2.19.12.7 Ensure that in the event of a pandemic, natural disaster, or man-made emergency, including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies, or other events which leads to a significant disruption in operations due to staff absence and/or loss of utilities, the Contractor's core

eligibility/Enrollment and Claims processing system shall be back on line within seventy-two (72) hours of the failure's or disaster's occurrence;

2.19.12.8 Notify designated LDH staff via phone and electronic mail within sixty (60) minutes of discovery of a problem within or outside the Contractor's Span of Control that may jeopardize or is jeopardizing availability and performance of critical systems functions and the availability of critical information as defined in this Section, including any problems impacting scheduled exchanges of data between the Contractor and LDH, the FI, or any other State vendors or systems. In its notification, the Contractor shall explain in detail the impact to critical path processes such as Enrollment management and Encounter submission processes;

2.19.12.9 Notify designated LDH staff via phone and electronic mail within fifteen (15) minutes of discovery of a problem that results in delays in report distribution or problems in online access to critical systems functions and information, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocol;

2.19.12.10 Provide information on System unavailability events, as well as status updates on problem resolution, to appropriate LDH staff. At a minimum, these updates shall be provided on an hourly basis until resolution and made available via phone and/or electronic mail;

2.19.12.11 Resolve and implement system restoration within sixty (60) minutes of official declaration of unscheduled System unavailability of critical functions caused by the failure of system and telecommunications technologies within the Contractor's Span of Control. Unscheduled System unavailability to all other System functions caused by system and telecommunications technologies within the Contractor's Span of Control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability;

2.19.12.12 Cumulative Systems unavailability caused by systems and/or IS infrastructure technologies within the Contractor's Span of Control shall not exceed twelve (12) hours during any continuous twenty (20) Business Day period; and

2.19.12.13 Within five (5) Business Days of the occurrence of a problem with system availability, the Contractor shall provide LDH with full written documentation that includes a Corrective Action Plan describing how the Contractor shall prevent the problem from reoccurring.

2.19.13 Off Site Storage and Remote Back-up

2.19.13.1 The Contractor shall provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.

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

2.19.13.2.1 Descriptions of the controls for back-up processing, including how frequently back-ups occur;

2.19.13.2.2 Documented back-up procedures;

2.19.13.2.3 The location of data that has been backed up (off-site and on-site, as applicable);

2.19.13.2.4 Identification and description of what is being backed up as part of the back-up plan;

2.19.13.2.5 Any change in back-up procedures in relation to the Contractor's technology changes; and

2.19.13.2.6 A list of all back-up files to be stored at remote locations and the frequency with which these files are updated.

2.19.14 Records Retention

2.19.14.1 The Contractor shall have online retrieval and access to documents and files for audit and reporting purposes for ten (10) years following termination of the Contract in live systems and an additional four (4) years in archival systems. Historical Encounter Data submission shall be retained for a period not less than ten (10) years following termination of the Contract, following generally accepted retention guidelines. Services which have a once in a lifetime indicator (e.g., appendix removal, hysterectomy) are denoted on LDH's procedure formulary file, and Claims shall remain in the current/active Claims history that is used in Claims editing and are not to be archived or purged. Online access to Claims processing data shall be by the Medicaid recipient ID, provider ID, provider NPI, and/or ICN (internal control number) to include pertinent Claims data and Claims status.

2.19.14.2 Audit trails shall be maintained online for no less than six (6) years following termination of the Contract.

2.19.14.3 The Contractor shall provide access to information in machine-readable format within forty-eight (48) hours of requests for information less than six (6) years old and within seventy-two (72) hours of requests for information greater than six (6) years old.

2.19.14.4 If an audit or administrative, civil, or criminal investigation or prosecution is in progress or unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

2.19.14.5 Under no circumstances shall the Contractor destroy or dispose of any such records, even after the expiration of the retention periods provided above, without the express prior written permission of LDH, which shall not be unreasonably withheld.

2.19.15 Information Security and Access Management

The Contractor's system shall:

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

2.19.15.1.1 Establish unique access identification per MCO employee;

2.19.15.1.2 Restrict access to information on a "least privilege" basis, such as users permitted inquiry privileges only shall not be permitted to modify information;

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

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

2.19.15.2 Make System information available to LDH, its designees, and other State and Federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

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

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

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

2.19.15.4.2 Have the date and identification "stamp" displayed on any online inquiry;

2.19.15.4.3 Have the ability to trace data from the final place of recording back to its source data file and/or document;

2.19.15.4.4 Be supported by listings, transaction reports, update reports, transaction logs, or error logs; and

2.19.15.4.5 Facilitate auditing of individual records as well as batch audits.

2.19.15.5 Have inherent functionality that prevents the alteration of finalized records;

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

2.19.15.7 Restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access;

2.19.15.8 Include physical security features designed to safeguard processor sites through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel;

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

2.19.15.10 Ensure that remote access users of its Systems can only access said Systems through two-factor user authentication and via methods such as VPN, which must be prior approved by LDH in writing as part of Readiness Review;

2.19.15.11 Comply with recognized industry standards governing security of State and Federal automated data processing systems and information processing. At a minimum, the Contractor shall conduct a security risk assessment and communicate the results in an Information Security Plan provided to LDH or its designee during Readiness Review. The risk assessment shall also be made available to appropriate Federal agencies;

2.19.15.12 Ensure appropriate protections of shared Personally Identifiable Information ("PII"), in accordance with 45 CFR §155.260; and

2.19.15.13 Ensure that its system is operated in compliance with the CMS' latest version of the Minimum Acceptable Risk Standards for Exchanges (MARS-E) Document Suite, currently MARS-E version 2.2.

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

2.19.15.13.2 A site-to-site tunnel is an extension of LDH's network. For contractors that are utilizing a VPN site-to-site tunnel and also have remote users who access CMS data, the contractor is responsible for providing and enforcing multi-factor authentication. Contractors that do not

utilize a VPN site-to-site tunnel will be charged for dual authentication licensing and hardware tokens as necessary. Costs associated with the purchase and any replacement of lost hardware tokens will be charged to the contractor.

2.20 Fraud, Waste, and Abuse Prevention

2.20.1 General Provisions

2.20.1.1 The Contractor and its Subcontractors shall comply with all applicable Federal and State laws, regulations, rules, policies, procedures, and manuals relating to Fraud, Waste, and Abuse in the Louisiana Medicaid Program, including, but not limited to, 42 CFR §438.1-438.608; La. R.S. 46:437.1-437.14; 42 CFR §455.12 – 455.23; LAC 50:I.4101-4235; and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.

2.20.1.2 The Contract Compliance Officer and CEO or COO shall meet in person, unless otherwise approved by LDH in writing, with LDH and MFCU at LDH's request to discuss Fraud, Waste, Abuse, neglect and overpayment issues. For purposes of this Section, the Contract Compliance Officer shall serve as the primary point of contact for the Contractor on issues related to Fraud, Waste, and Abuse Prevention.

2.20.1.3 The Contractor and its Subcontractors shall cooperate and assist the State and any State or Federal agency charged with the duty of identifying, investigating, or prosecuting suspected Fraud, Waste, or Abuse. During Business Hours, CMS, the OIG, HHS, LLA, the Office of the Attorney General, GAO, LDH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of ten (10) years following termination of the Contract or from the date of completion of any audit, whichever is later, shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the Contract and any other applicable rules. MFCU shall be allowed access to the Contractor's place of business and to all Louisiana Medicaid Program records of any contractor, Subcontractor, or provider during Business Hours, except under special circumstances determined by the MFCU when after-hours admission shall be allowed.

2.20.1.4 The Contractor and its providers and Subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above upon request. HHS, OIG, LDH, GAO, LLA, the Office of the Attorney General, and/or the designees of any of the above shall have Timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with any and all Contractor clients, employees, and contractors, and do on-site reviews of all matters relating to service

delivery as specified by the Contract. The records provided for review shall be non-redacted.

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2.20.1.5 The Contractor and its providers and Subcontractors shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested and shall not be redacted. If a provider fails to respond to a request from the Contractor and/or fails to substantially comply with the requested record(s) or information from the Contractor, the Contractor shall place the provider on a payment suspension or payment withhold until the record(s) or information is produced or the provider notifies the Contractor in writing that the record or information cannot be produced.

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2.20.1.6 The Contractor's employees, consultants, and its Subcontractors and their employees shall cooperate fully and be available in person for interviews, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other investigative or judicial processes. The Contractor is responsible for any costs incurred.

2.20.1.7 The Contractor shall certify all statements, reports and Claims, financial and otherwise, as true, accurate, non-redacted and complete. The Contractor shall not submit for payment purposes those Claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, Waivers, the Contract, and the **MCO Manual**.

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2.20.1.8 The Contractor and its Subcontractors shall have programs and procedures pursuant to 42 CFR §438.608(a)(1) to safeguard Louisiana Medicaid Program funds against unnecessary or inappropriate use of Medicaid Covered Services and against improper payments. The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected Fraud, Waste, and Abuse activities.

2.20.1.9 Unless the Contractor has verified and confirmed that the provider is enrolled with the State or until the State implements its own screening of MCO-only providers and has notified the Contractor that it has fully assumed this function, the Contractor, as well as its Subcontractors and providers, shall comply with all federal requirements (42 CFR Part 455, Subpart B and 42 CFR Part 438, Subpart H) on disclosure reporting. If the Contractor cannot verify and confirm that provider is enrolled with the State, the Contractor shall ensure that provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract submit routine disclosures to the Contractor in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including:

2.20.1.9.1 Upon the provider submitting an application for enrollment;

2.20.1.9.2 Upon the provider executing a Network Provider Agreement;

2.20.1.9.3 Upon revalidation; and

2.20.1.9.4 Within thirty-five (35) Calendar Days after any change of ownership has occurred.

2.20.1.10 The Contractor, as well as its Subcontractors and providers, shall comply with all Federal requirements (42 CFR Part 1002) on exclusion and debarment screening. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the Contractor dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

2.20.1.11 The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement Corrective Action Plans to assist the Contractor in preventing and detecting potential Fraud, Waste, and Abuse. At a minimum, the Contractor shall have one (1) full-time investigator physically located within Louisiana for every fifty thousand (50,000) Enrollees or fraction thereof. LDH may approve written requests with detailed justification to substitute another SIU position in place of an investigator position.

2.20.1.12 Reporting and Investigating Suspected Fraud and Abuse

2.20.1.12.1 The Contractor shall have methods for identification, investigation, and referral of suspected Fraud cases (42 CFR §455.13, §455.14, and §455.21) both internally and for its Subcontractors.

2.20.1.12.2 The Contractor shall report all tips, confirmed or suspected Fraud, Waste, and Abuse to LDH and the appropriate agency as follows:

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

2.20.1.12.2.2 Triage and/or substantiate tips and provide updates to MFCU and LDH when the concerns and/or allegations of any tips are authenticated;

2.20.1.12.2.3 Suspected Fraud and/or Abuse in the administration of the program shall be reported in writing to LDH Program Integrity and MFCU within three (3) Business Days of the Contractor becoming aware of the issue;

2.20.1.12.2.4 All confirmed or suspected provider Fraud and Abuse shall be reported in writing to LDH Program Integrity and MFCU within **forty-eight (48) hours**; and

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2.20.1.12.2.5 All confirmed or suspected Enrollee Fraud and Abuse shall be reported i, in writing, to LDH Program Integrity and local law enforcement of the Enrollee's parish of residence within **forty-eight (48) hours**.

2.20.1.12.3 When making a referral of suspected or confirmed Fraud and Abuse, the Contractor shall utilize the **LDH Provider Fraud Referral Form** available in the **MCO Manual**.

2.20.1.12.4 The Contractor shall promptly perform a preliminary investigation of all allegations, tips, or complaints of Fraud and Abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting Fraud or suspected Fraud and/or suspected Abuse and/or confirmed Abuse, the Contractor shall not take any of the following actions as they specifically relate to Louisiana Medicaid Program Claims:

2.20.1.12.4.1 Contact the subject of the investigation about any matters related to the investigation;

2.20.1.12.4.2 Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

2.20.1.12.4.3 Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

2.20.1.12.5 The Contractor shall provide the results of its preliminary investigation to LDH or the agency to whom the incident was reported, or to another agency designated by the agency that received the report.

2.20.1.12.6 The Contractor and its Subcontractors shall seek to reduce prospective financial loss to health Fraud, Waste, and Abuse when fraudulent and/or criminal activity is suspected through pre-payment reviews and/or post-payment review, audit or investigations.

2.20.1.12.6.1 The Contractor may mitigate loss of funds to Fraud by employing procedures including, but not limited to, pre-payment edits, Prior Authorization, medical necessity review, verification of services being rendered as billed, payment withhold in full or in part, Corrective Action Plans, termination of the Network Provider Agreement, or other remedies.

2.20.1.12.6.2 Pursuant to La. R.S. 46:460.76, Pre-Payment Review shall be limited to requirements that are implemented directly by LDH and in accordance with the provisions of the Medical Assistance Programs Integrity Law, La. R.S. 46:437.1 et seq.

2.20.1.12.7 The Contractor and/or its Subcontractors shall suspend payment to a Network Provider when the State determines there is a credible allegation of Fraud, unless the State determines there is cause for not suspending payments to the Network Provider pending the investigation. The Contractor is responsible for sending the Network Provider the required notice and Appeal rights as required by 42 CFR §455.23.

2.20.1.13 The Contractor and/or Subcontractors shall include in all of its Network Provider Agreements a provision (1) notifying the provider that the

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payment of any claims are from federal and state funds; (2) the provider is required to adhere to all standards and requirements related to the provision of services paid in whole or part by the Mediciad program; (3) the provider is required to adhere to all federal and state statutes, regulations and contractual provisions governing the conduct of providers within the Medicaid program, including but not limited to the FCA, MAPIL, SURS regulations, and Part 2.20 of this contract; and (4) when submitting claims the provider is certifying the claim is true and correct in all material aspects of the claim and is supported by adequate documentation, and (5) requiring, as a condition of receiving any amount of Louisiana Medicaid Program payment, that the provider complies with this Section of the Contract.

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2.20.2 Fraud, Waste, and Abuse Compliance Plan

2.20.2.1 In accordance with 42 CFR §438.608(a), the Contractor and its Subcontractors, to the extent that the Subcontractor is delegated responsibility by the Contractor for coverage of services and payment of Claims under the Contract between the Contractor and the State, shall implement and maintain a compliance program that includes arrangements or procedures designed to prevent and detect Fraud, Waste, and Abuse.

2.20.2.2 In accordance with 42 CFR §438.608(a), the arrangements and procedures of the compliance program shall include all of the following elements:

2.20.2.2.1 Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Contract, and all applicable Federal and State requirements.

2.20.2.2.2 The designation of a Contract Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors.

2.20.2.2.3 The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Contract.

2.20.2.2.4 A system for training and education for the Contract Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the Contract.

2.20.2.2.4.1 Fraud, Waste, and Abuse Training shall include, but not be limited to:

Annual training of all employees; and

New hire training within thirty (30) Calendar Days of beginning date of employment.

2.20.2.2.4.2 The Contractor shall require new employees to complete and attest to training modules within thirty (30) Calendar Days of hire related to the following in accordance with applicable Federal and State laws, regulations, rules, and policies:

Contractor Code of Conduct Training;

Privacy and Security – Health Insurance Portability and Accountability Act;

Fraud, Waste, and Abuse identification and reporting procedures;

The False Claims Act and employee whistleblower protections;

Procedures for Timely consistent exchange of information and collaboration with LDH;

Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and

Provisions that comply with 42 CFR §438.608 and §438.610 and all relevant State and Federal laws, regulations, policies, procedures, and guidance (including CMS' *Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks*) issued by LDH, HHS, CMS, and OIG, including updates and amendments to these documents or any such standards established or adopted by the State of Louisiana or its agencies.

2.20.2.2.5 Effective lines of communication between the Contract Compliance Officer and the organization's employees.

2.20.2.2.6 Enforcement of standards through well-publicized disciplinary guidelines.

2.20.2.2.7 Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.

2.20.2.2.8 Procedures for prompt notification to LDH when the Contractor receives information about changes in an Enrollee's circumstance that may affect the Enrollee's eligibility including changes in the Enrollee's residence and death of an Enrollee.

2.20.2.2.9 Procedures for prompt notification to LDH when the Contractor receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the program.

2.20.2.2.10 Procedures to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Enrollees and the application of such verification on a regular basis.

2.20.2.2.11 Provision for the Contractor's suspension of payments to a Network Provider for which the State determines there is a credible allegation of Fraud in accordance with 42 CFR §455.23.

2.20.2.2.12 Procedures for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract.

2.20.2.2.13 Protections to ensure that no individual who reports program integrity related violations or suspected Fraud, Waste, and/or Abuse is retaliated against by anyone who is employed by or contracts with the Contractor. The Contractor shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidential to the extent possible. Anyone who believes that he or she has been retaliated against may report this violation to LDH and/or the U.S. Office of Inspector General.

2.20.2.2.14 Procedures for a Network Provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within sixty (60) Calendar Days of the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment.

2.20.2.2.15 Procedures for reporting within thirty (30) Calendar Days to the State all overpayments identified and recovered, specifying the overpayments due to potential Fraud.

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2.20.2.3 In addition to the arrangements and procedures specified in 42 CFR §438.608(a), the Contractor's compliance program shall incorporate the following requirements:

2.20.2.3.1 Detection and prevention of Louisiana Medicaid Program violations and possible Fraud, Waste, and Abuse overpayments through data matching, trending, statistical analysis, monitoring service and billing patterns, monitoring Claims edits, and other data mining techniques.

2.20.2.3.2 Descriptions of specific controls in place for prevention and detection of potential or suspected Fraud, Waste, and Abuse, including: lists of pre-payment Claims edits, post-payment Claims edits, post-payment Claims audit projects, data mining and provider profiling algorithms, and references in provider and Member Materials relative to identifying and reporting Fraud to the Contractor and law enforcement.

2.20.2.3.3 Provisions for the confidential reporting of plan violations, such as a dedicated toll-free hotline to report violations and a clearly designated individual, such as the Contract Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of Fraud so that such reports cannot be diverted by supervisors or other personnel.

2.20.2.3.4 Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.

2.20.2.4 Effective implementation of a well-publicized email address for the dedicated purpose of reporting Fraud. This email address must be made available to Enrollees, providers, Contractor employees and the public on the Contractor's website required under this Contract. The Contractor shall implement procedures to review complaints filed in the Fraud reporting email account at least weekly, and investigate and act on such complaints as warranted.

2.20.2.5 The Contractor shall submit to LDH or its designee the Fraud, Waste, and Abuse Compliance Plan as part of Readiness Review, annually thereafter, and upon updates or modifications for written approval at least thirty (30) Calendar Days in advance of making them effective. LDH, at its sole discretion, may require that the Contractor modify its compliance plan.

2.20.3 Prohibited Affiliations

2.20.3.1 In accordance with 42 CFR §438.610, the Contractor and its Subcontractors are prohibited from knowingly having a relationship with:

2.20.3.1.1 An individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

2.20.3.1.2 An individual or entity that is excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a.

2.20.3.2 The Contractor shall not have a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with:

2.20.3.2.1 An individual convicted of crimes described in 42 U.S.C. §1320a-7(b)(8)(B);

2.20.3.2.2 Any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

2.20.3.2.3 Any individual or entity that is excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a.

2.20.3.3 The Contractor is prohibited from employing or contracting, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with:

2.20.3.3.1 Any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;

2.20.3.3.2 Any individual or entity that is excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a;

2.20.3.3.3 Any individual or entity that would (or is affiliated with a person/entity that would) provide those services through an individual or entity debarred, suspended, or excluded from

participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

2.20.3.3.4 Any individual or entity that would provide those services through an individual or entity excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a.

2.20.3.4 The Contractor is prohibited from being controlled by a sanctioned individual under 42 U.S.C. §1320a-7(b)(8).

2.20.3.5 If LDH finds the Contractor is not in compliance with 42 CFR §438.610(a) and (b), LDH:

2.20.3.5.1 Shall notify the Secretary of the U.S. Department of Health and Human Services (HHS) of the noncompliance;

2.20.3.5.2 May continue an existing agreement with the Contractor unless the Secretary of HHS directs otherwise;

2.20.3.5.3 May not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary of HHS provides to LDH and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations; and

2.20.3.5.4 Nothing in this section shall be construed to limit or otherwise affect any remedies available to the HHS under 42 U.S.C. §1320a-7, §1320a-7a, and §1320a-7b.

2.20.3.6 The Contractor and its Subcontractors shall comply with all applicable provisions of 42 CFR §438.608 and §438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. Unless a provider has previously been screened by LDH pursuant to 42 CFR §455.436, the Contractor and its Subcontractors shall screen all employees, contractors, and providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any Federal health care programs. To help make this determination, the Contractor shall conduct screenings to comply with the requirements set forth at 42 CFR §455.436, except when the Contractor has verified and confirmed that a provider is enrolled with the State.

2.20.3.7 The Contractor and its Subcontractors shall conduct a search of the OIG LEIE, Louisiana Adverse Actions List Search, SAM, and other applicable sites as may be determined by LDH, monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered shall be reported to LDH within three (3) Business Days. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from the

Louisiana Medicaid Program for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This is a prohibited affiliation. This prohibition applies even when the Louisiana Medicaid Program payment itself is made to another provider who is not excluded. [See 42 U.S.C. §1320a-7a(a)(6) and 42 CFR §1003.102(a)(2).]

2.20.3.8 An individual who is an Affiliate of a prohibited person or entity described above can include:

2.20.3.8.1 A director, officer, or partner of the Contractor;

2.20.3.8.2 A Subcontractor of the Contractor;

2.20.3.8.3 A person with an employment, consulting or other arrangement with the Contractor for the provision of items and services which are significant and material to the Contractor's obligations under this Contract; or

2.20.3.8.4 A Network Provider.

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

2.20.3.10 The Contractor, through its Contract Compliance Officer, shall attest monthly to LDH that it has screened all employees and Subcontractors as specified in the *Debarment/Suspension/Exclusion* section.

2.20.3.11 The Contractor, through its Contract Compliance Officer, shall attest monthly to LDH that it has screened all providers as specified in the *Debarment/Suspension/Exclusion* section or that it has verified and confirmed that the provider is enrolled with the State.

2.20.3.12 The Contractor and its Subcontractors shall retain the data, information, and documentation specified in 42 CFR §438.410, for a period of no less than ten (10) years following termination of the Contract.

2.20.4 Payments to Excluded Providers

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

2.20.4.2 LDH may recover from the Contractor, via a deduction from the MCO's Capitation Payment, any money paid for services provided by an excluded provider.

2.20.5 Reporting

2.20.5.1 The Contractor and its Subcontractors shall be responsible for promptly reporting suspected or confirmed Fraud, Waste, Abuse, and neglect information to the Louisiana Office of Attorney General MFCU and LDH within forty-eight (48) hours after discovering suspected incidents, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).

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2.20.5.2 The Contractor shall notify LDH within three (3) Business Days of the time it receives notice that action is being taken against the Contractor or Contractor's employee, Network Provider, Subcontractor or Subcontractor's employee under the provisions of 42 U.S.C. §§1320a - 1320b, which could result in exclusion, debarment, or suspension of the Contractor, Network Provider, or a Subcontractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

2.20.5.3 The Contractor shall report to LDH, within three (3) Business Days, when it has discovered that any Contractor employee(s), Network Provider, Subcontractor, or Subcontractor's employee(s) have been excluded, suspended, or debarred from any State or Federal health care benefit program via the designated LDH Program Integrity contact.

2.20.5.4 Reporting shall include, but is not limited to, the following, as set forth at 42 CFR §455.17:

2.20.5.4.1 Number of complaints of Fraud, Waste, Abuse, neglect, and overpayments made to the Contractor that warrant preliminary investigation (under 42 CFR §455.14);

2.20.5.4.2 Number of complaints reported to the Contract Compliance Officer; and

2.20.5.4.3 For each complaint that resulted in the Contractor conducting a full investigation in accordance with 42 CFR §455.15 and §455.16, the Contractor shall provide LDH, at a minimum, the following:

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2.20.5.4.3.1 Provider name and ID number;

2.20.5.4.3.2 Source of complaint;

2.20.5.4.3.3 Type of provider;

2.20.5.4.3.4 Nature of complaint;

2.20.5.4.3.5 Approximate amount of dollars involved if applicable; and

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

2.20.5.5 The Contractor shall report to LDH Program Integrity monthly and quarterly all audits performed and overpayments identified and recovered by the Contractor and all of its Subcontractors. [See 42 CFR §438.608(d)(3).]

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2.20.5.6 The Contractor shall report overpayments made by LDH to the Contractor within sixty (60) Calendar Days from the date the overpayment was identified.

2.20.5.7 The Contractor shall report to LDH Program Integrity quarterly all unsolicited provider refunds, which shall include any payments submitted to the Contractor and/or its Subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.

2.20.6 Rights of Review and Recovery by Contractor and LDH

2.20.6.1 The Contractor and its Subcontractors are responsible for investigating and reporting possible acts of provider Fraud, Waste, and Abuse for all services under this Contract.

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

2.20.6.3 The Contractor and its Subcontractors shall have the right to audit, review and investigate providers and Enrollees within the Contractor's network for a five (5) year period from the date of service of a Claim via "complex" review. A complex review is one for which the review of medical, financial, and/or other records, including those onsite, were necessary to determine the existence of an improper payment. In determining the amount of an overpayment during a complex review, the Contractor and its Subcontractors shall give consideration for the amount the Medicaid program would have paid had the provider billed the claim correctly.The collected funds from the Contractor's complex reviews are to remain with the Contractor.

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2.20.6.4 All complex reviews shall be completed within ten one year (three hundred sixty-five (365) Calendar Days) of the date the case was opened unless an extension is authorized by LDH. This review period is inclusive of all provider notifications, health plan document reviews, and includes any Provider Appeal or rebuttal process.

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2.20.6.4.1 Before the Contractor executes a recoupment related to Fraud, Waste, or Abuse under investigation by the Contractor's Special Investigation Unit (SIU), the provider shall have forty-five (45) Calendar Days from receipt of written notification addressed from the Contractor's SIU of findings and/or recoupment to submit a written response to the Contractor as to why the findings and/or recoupment are not valid or should not be put into effect on the date specified in the notice. If the provider fails to submit a written response within the time period provided, the Contractor may execute the recoupment on the date specified in the notice. All Fraud, Waste, or Abuse recoupment notifications shall include the information listed in the Payment Recoupments section of this Contract.

2.20.6.5 The Contractor shall ensure compliance with all requirements of La. R.S. 46:460.72-460.73, including the requirement to void all Claims and Encounters associated with Fraud, Waste, and Abuse for the purpose of reducing PMPM rates, thereby returning overpayments to the State. The Contractor shall comply with the timelines specified in the **MCO Manual** for voiding such Encounters.

2.20.6.6 LDH or its designee will notify the Contractor when it is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or Claims upon which the recoupment or withhold are based meet the following criteria:

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2.20.6.6.1 The improperly paid funds have already been recovered by the State of Louisiana, either by Louisiana Medicaid Program directly or as part of a resolution of a State or Federal investigation, audit, and/or lawsuit including, but not limited to, False Claims Act cases; or

2.20.6.6.2 When the issues, services, or Claims that are the basis of the recoupment or withhold are the subject of pending State or Federal investigation, audit, and/or lawsuit.

2.20.6.7 The prohibition described in the preceding section shall be limited to a specific provider(s), for specific dates, and for specific issues, services, or Claims. In the event that the Contractor obtains funds in cases where recovery, recoupment or withhold is prohibited under this Section, LDH may recover the funds from the Contractor.

2.20.6.8 Contact with a provider shall be prohibited in instances resulting from suspected or confirmed Fraud, which the Contractor has identified and submitted a referral of Fraud to LDH, MFCU, or other appropriate law enforcement agency, until approved by LDH in writing.

2.20.6.9 If the Contractor fails to collect at least a portion of an identified recovery after three hundred sixty-five (365) Calendar Days from the date that the investigation was completed, unless an extension or exception is authorized in writing by LDH, and the Contractor has documented recovery efforts deemed sufficient by LDH upon review, including formally initiating collection efforts, LDH or its agent may recover the overpayment from the Contractor and said funds shall be retained by the State. Exception reasons may include, but are not limited to, Contractor cooperation with LDH or other government agencies, termination of provider participation with the Contractor, or dissolution of the provider's business.

2.20.6.10 LDH or its agent shall have the right to audit, review and investigate providers and Enrollees within the Contractor's network via "complex" or "automated" review. LDH may recover from the Contractor, via a deduction from the Contractor's Capitation Payment, and the Contractor may initiate a payment withhold from the provider for all of the following amounts assessed to a provider as a result of LDH's audit, whether the provider is excluded from the Medicaid program or not:

- Monetary Penalties and/or Sanctions assessed in accordance with the MAPIL's recovery provisions (La. R.S. 46:438.6(A), (B), (C), and (D)), and/or the SURS Rule (LAC 50:I.4161.A.18) and any successor statutes or regulations;
- State-identified improper payments and overpayments;
- Overpayments determined through statistical sampling (extrapolation); and
- Investigation costs.

2.20.6.10.1 The recovered funds shall be retained by the State.

2.20.6.10.2 The Contractor may pursue recovery from the provider. However, the Contractor is prohibited from recouping a State-identified overpayment from a provider when the Contractor is responsible for the overpayment, unless approved in writing by LDH. The Contractor shall submit corrected Encounter Data within forty-five (45) Calendar Days of notice of the overpayment from LDH, regardless of whether the MCO recovers the overpayment from the provider.

2.20.6.11 LDH shall not initiate its own review on the same Claims for a Network Provider which has been identified by the Contractor as under a review

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approved by LDH. LDH shall track open LDH and Contractor reviews to ensure audit coordination.

2.20.6.12 In the event LDH or its agent initiates a review on a Network Provider, a notification shall be sent to the Contractor Special Investigation Unit (SIU) designee. The LDH notification of the intent to review shall include provider name, NPI, city, and provider type, allegation or issue being reviewed, procedure codes or NDCs under review, date range for dates of service under review, and amount paid. The Contractor shall have ten (10) Business Days to indicate whether the Claims were corrected or adjusted prior to the date of the notification from LDH. If the State does not receive a response from the Contractor within ten (10) Business Days, the State may proceed with its review.

2.20.6.13 In the event the State or its agent investigates, reviews, or audits a provider or Enrollee within the Contractor's Network, the Contractor shall comply with document and Claims requests from the State within fourteen (14) Calendar Days of the request, unless another time period is agreed to in writing by the Contractor and State.

2.20.6.14 LDH shall notify the Contractor and the Network Provider of overpayments identified by the State or its agents.

2.20.6.15 Upon the conclusion of provider rebuttals and Appeals, if applicable, the State or its agent shall notify the Contractor of the overpayment. The Contractor shall initiate its own review on the identified Encounters within fourteen (14) Calendar Days of notification from LDH and correct the identified Encounters within forty-five (45) Calendar Days of notification from LDH. The Contractor shall submit confirmation that the corrections have been completed.

2.20.6.16 The Contractor and its Subcontractors shall enforce LDH directives regarding sanctions on its Network Providers and Enrollees, including, but not limited to, payment suspension, termination or exclusion from the network.

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2.20.6.17 There shall be no LDH provider improper payment recovery request of the Contractor applicable for the dates of service occurring before the Operational Start Date or for providers for which no MCO relationship existed.

2.20.6.18 The Contractor shall not remit payment to any provider for which the State-issued Medicaid Provider Identifier number has been revoked or terminated by LDH.

2.20.6.19 The Contractor and its Subcontractors shall retain all data, information, and documentation specified in 42 CFR §438.608 for a period of no less than ten (10) years following termination of the Contract.

2.20.6.20 Upon approval from LDH, the Contractor may extrapolate an overpayment amount. The approval process is specified in the MCO Manual.

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2.20.7 Program Integrity Requirements

The Contractor shall meet following requirements:

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

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2.20.7.2 Notify LDH in writing upon receipt of any voluntary provider disclosures resulting in receipt of overpayments in excess of twenty-five thousand dollars ($25,000), even if there is no suspicion of fraudulent activity; and

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

PART 3: STATE RESPONSIBILITIES

3.1 Contract Management

BHSF is responsible for the primary oversight of the Contract, including Louisiana Medicaid Program policy decision-making and Contract interpretation. As appropriate, BHSF shall provide clarification of Contract requirements and Louisiana Medicaid Program policy, regulations and procedures and shall schedule meetings as necessary with the Contractor.

3.1.1 Contract Administration Personnel

3.1.1.1 The Contract Compliance Officer, described in the *Administration & Contract Management* section, shall facilitate the establishment and maintenance of direct relationships between the appropriate LDH Business Owners and Contractor employees with corresponding responsibilities for the duration of the Contract.

3.1.1.2 The Contract Compliance Officer shall introduce Contractor employees newly placed in a position to the relevant LDH Business Owners, based on roles and responsibilities, within five (5) Business Days of the placement.

3.1.2 Contract Monitor

Medicaid Executive Director or his/her Designee

Louisiana Department of Health

Bureau of Health Services Financing

628 North 4th St., 7th floor

Baton Rouge, LA 70802

3.1.3 Notices

Any notice given to a party under the Contract is deemed effective, if addressed to the Contract Monitor as addressed above, upon: (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by facsimile or email if a copy of the notice is sent by another means specified in this Section; (iii) the third (3rd) Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a tracking system.

Either party may change its address for notification purposes by providing written notice stating the change, effective date of the change and setting forth the new address at least ten (10) Business Days prior to the effective date of the change of address. If different representatives are designated after execution of the Contract, notice of the new

representatives shall be given in writing to the other party and attached to originals of the Contract.

Whenever LDH is required by the terms of this Contract to provide written notice to the Contractor, such notice shall be signed by the Medicaid Executive Director or his/her designee.

3.1.4 Required Submissions

3.1.4.1 The Contractor shall submit documents and information in accordance with this Contract and the **MCO Manual**. LDH shall have the right to approve, disapprove, or require modification of these documents, information, and any procedures, policies and materials related to the Contractor's responsibilities under the terms of the Contract.

3.1.4.2 LDH shall review reports to determine that they are complete and without error according to the reporting requirements provided in the **MCO Manual**. Any reports found to be incomplete or submitted with errors shall be returned to the Contractor for correction and resubmission within specified timeframes. LDH reserves the right to assess Monetary Penalties for failure to comply with reporting requirements.

3.1.5 Readiness Review

3.1.5.1 LDH or its designee will assess the performance of the selected MCOs prior to and after the begin date for operations in accordance with 42 CFR §438.66(d). LDH expects to complete the Readiness Review at least three (3) months prior to the Operational Start Date. Each Readiness Review for entities that did not contract with LDH as an MCO immediately prior to the Contract effective date shall be performed via a desk review of documents and on-site at the Contractor's Louisiana administrative offices and shall include an assessment of the Contractor's ability and capability to perform satisfactorily in the areas noted below as set forth in 42 CFR §438.66(d)(4). All selected MCOs must participate in a comprehensive Readiness Review if required by LDH; however, LDH retains the discretion to conduct a more limited Readiness Review for existing MCO contractors. LDH or its designee may conduct additional Readiness Reviews of the Contractor prior to enrolling additional populations in managed care or prior to adding or deleting MCO Covered Services from Attachment B, *MCO Covered Services*.

3.1.5.2 The scope of the Contractor's Readiness Review may include, but is not limited to, a review of the following elements against the requirements provided in this Contract and the **MCO Manual**:

3.1.5.2.1 Administrative staffing and resources, including key personnel;

3.1.5.2.2 Delegation and oversight of Contractor responsibilities, including capabilities of Material Subcontractors;

3.1.5.2.3 Enrollee and provider communications, including Enrollee services capability;

3.1.5.2.4 Grievance and Appeals;

3.1.5.2.5 Enrollee services and outreach, including Marketing Materials;

3.1.5.2.6 Provider network management plans and model Network Provider Agreements, including any provider performance incentives;

3.1.5.2.7 Program integrity and compliance, including Fraud, Waste, and Abuse;

3.1.5.2.8 Service delivery, including care management capabilities, quality management and quality improvement, and utilization review;

3.1.5.2.9 Financial management, including financial reporting and monitoring and financial solvency; and

3.1.5.2.10 Systems management, including Claims management, Encounter Data and Enrollee information management, and, at the request of LDH, a walk-through of any information systems, interfacing and reporting capabilities, and validity testing of Encounter Data, including IT testing and security assurances.

3.1.5.3 LDH shall not enroll Potential Enrollees with the Contractor until LDH determines that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review, except as provided below.

3.1.5.4 LDH shall identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and may, in its discretion:

3.1.5.4.1 Allow the Contractor to propose a plan to remedy all deficiencies prior to the Operational Start Date;

3.1.5.4.2 Postpone the Operational Start Date for the Contractor if the Contractor fails to satisfy all Readiness Review requirements; or

3.1.5.4.3 Enroll Enrollees with the Contractor as of the Operational Start Date provided the Contractor and LDH agree on a Corrective Action Plan to remedy any deficiencies.

3.1.5.5 If, for any reason, the Contractor does not fully satisfy LDH that it is ready and able to perform its obligations under the Contract prior to the Operational Start Date, and LDH does not agree to postpone the Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then LDH may terminate the Contract and shall be entitled to recover damages from the Contractor.

3.1.5.6 LDH shall submit the results of the Readiness Review to CMS in order for CMS to make a determination that the Contract or associated Contract amendment is approved under 42 CFR §438.3(a).

3.1.6 Ongoing Contract Monitoring

LDH shall monitor the Contractor's performance to ensure the Contractor is in compliance with Contract provisions. The Contractor remains responsible for continuously monitoring the performance of its Material Subcontractors and providers and their compliance with Contract provisions. LDH may develop, based on its ongoing monitoring, a public performance dashboard displaying the Contractor's performance.

3.1.6.1 LDH or its designee shall coordinate with the Contractor to establish the scope of the monitoring review, the review site, if on-site, relevant timeframes for obtaining information, and the criteria for review.

3.1.6.2 LDH or its designee shall monitor the operation of the Contractor for compliance with the provisions of this Contract, and all applicable Federal and State laws and regulations. Inspection may include the Contractor's facilities, as well as auditing and/or review of all records developed under this Contract including, but not limited to, periodic medical audits, Grievances, Enrollments, Disenrollments, utilization and financial records, review of the management systems and procedures developed under this Contract and any other areas or materials relevant or pertaining to this Contract.

3.1.6.3 The Contractor shall provide access to documentation, medical records, premises, and staff as deemed necessary by LDH.

3.1.6.4 LDH shall provide the Contractor with the right to review and comment on any of the findings and recommendations resulting from Contract monitoring and audits, except in the cases of Fraud investigations or criminal action. Once LDH finalizes the results of monitoring and/or the audit report, the Contractor shall comply with all recommendations resulting from the review. Failure to comply with recommendations for improvement may result in Monetary Penalties, administrative actions, Enrollment restrictions, and/or contract termination.

3.1.7 MCO On-Site Reviews

In addition to the on-site component of Readiness Reviews for the Contractor, LDH or its designee may conduct on-site reviews at any time during the course of the Contract to monitor Contractor performance or assess compliance of any contractual requirement.

3.1.8 Regular Contract Monitoring Meetings

LDH shall assess and communicate feedback on overall plan performance to the Contractor through routine meetings with Contractor leadership, including but not limited to:

3.1.8.1 Monthly in-person or telephonic meetings between the Medicaid Executive Director, Medicaid Deputy Director responsible for the Managed Care Program, and the Contractor's CEO.

3.1.8.2 Quarterly performance reviews wherein Contractor leadership present to LDH leadership on overall Contractor performance relative to LDH goals and the requirements of the Contract. The reviews shall take place in-person at LDH headquarters on a schedule determined by LDH. LDH shall notify the Contractor of the schedule and any format or content requirements thirty (30) Calendar Days prior to the review date. Unless otherwise specified by LDH in writing, in-person attendance of the following Contractor staff is mandatory:

3.1.8.2.1 Chief Executive Officer (CEO);

3.1.8.2.2 Medical Director;

3.1.8.2.3 Behavioral Health Medical Director;

3.1.8.2.4 Chief Operating Officer (COO);

3.1.8.2.5 Chief Financial Officer (CFO);

3.1.8.2.6 Quality Management Coordinator;

3.1.8.2.7 Provider Services Manager;

3.1.8.2.8 Case Management Administrator/Manager; and

3.1.8.2.9 Other staff as designated by LDH based on content.

3.1.9 Contractor Monitoring

3.1.9.1 LDH shall:

3.1.9.1.1 Monitor compliance with the terms of the Contract;

3.1.9.1.2 Receive and respond to all inquiries and requests made by the Contractor under this Contract, in the time frames specified by the Contract;

3.1.9.1.3 Meet with the Contractor's representative on a periodic or as needed basis and resolve issues that arise;

3.1.9.1.4 Ensure that LDH staff with appropriate expertise in clinical, financial, data, systems, Marketing, Enrollment, and quality management matters, are involved in the Contractor's QAPI Program;

3.1.9.1.5 Ensure that appropriate staff from LDH agencies are available to assist the Contractor with care and service coordination activities;

3.1.9.1.6 Make best efforts to resolve any issues identified either by the Contractor or LDH that may arise that are applicable to the Contract;

3.1.9.1.7 Inform the Contractor of any discretionary action by LDH under the provisions of the Contract; and

3.1.9.1.8 Review and approve in writing:

3.1.9.1.8.1 Transition Work Plan;

3.1.9.1.8.2 Remedy plan for deficiencies identified prior to the Operational Start Date;

3.1.9.1.8.3 Key personnel and staffing plan;

3.1.9.1.8.4 Material subcontracts;

3.1.9.1.8.5 Performance review policies, procedures and work plan;

3.1.9.1.8.6 PCP Automatic Assignment methodology;

3.1.9.1.8.7 Material change in provider network;

3.1.9.1.8.8 Provider handbook;

3.1.9.1.8.9 Provider training manual and schedule;

3.1.9.1.8.10 Tentative prescriber training and education schedule or plan;

3.1.9.1.8.11 Utilization management reports;

3.1.9.1.8.12 Plan for long-term stays in EDs;

3.1.9.1.8.13 Press or media events/activities or activities that include sponsorships or grants;

3.1.9.1.8.14 Telephone help line policies and procedures;

3.1.9.1.8.15 Call center quality criteria and protocols;

3.1.9.1.8.16 Quality deficiencies which result in suspension or termination of a Network Provider/Subcontractor(s);

3.1.9.1.8.17 QAPI Program description;

3.1.9.1.8.18 Internal Claims dispute process;

3.1.9.1.8.19 Claims Payment Accuracy Percentage Report;

3.1.9.1.8.20 Pharmacy Benefits Manager (PBM);

3.1.9.1.8.21 Corrective action plans;

3.1.9.1.8.22 System update and/or change revisions;

3.1.9.1.8.23 Systems Refresh Plan;

3.1.9.1.8.24 Information Security Plan;

3.1.9.1.8.25 Fraud, Waste, and Abuse Compliance Plan;

3.1.9.1.8.26 VBP Strategic Plan;

3.1.9.1.8.27 Turnover Plan;

3.1.9.1.8.28 Turnover Results report;

3.1.9.1.8.29 Insurance policies;

3.1.9.1.8.30 Reinsurance agreements;

3.1.9.1.8.31 Continuity of Operations Plan;

3.1.9.1.8.32 Requests for exemptions to requirements as allowed by this Contract; and

3.1.9.1.8.33 Other deliverables and information as required in the Contract and **MCO Manual**.

3.1.9.2 If LDH determines that the Contractor is in violation of any of the terms of the Contract stated herein, at its sole discretion, it may apply one (1) or more of the actions provided in the *Contract Non-Compliance* section, including termination of the Contract; provided, however, that LDH shall only impose those actions that it determines to be reasonable and appropriate for the specific violation(s) identified.

3.1.9.3 LDH shall notify the Contractor, as promptly as is practicable, of any providers suspended or terminated from participation in the Louisiana Medicaid Program so that the Contractor may take action to remove such provider from their provider network.

3.1.10 Data Sharing

LDH shall share available public health data on Enrollees with the Contractor including, but not limited to, the following:

3.1.10.1 Immunization data for Enrollees through the month of their twenty-first (21st) birthday; and

3.1.10.2 Vital records data.

3.1.11 Coordination of Benefits

3.1.11.1 LDH or its contractor shall provide the Contractor with all third-party health insurance information on Enrollees when it has verified that third party health insurance exists.

3.1.11.2 When LDH has knowledge that an Enrollee has been involved in an accident or has had a traumatic event and a liable third party might exist, LDH shall notify the Contractor and provide the Enrollee's name and pertinent information.

3.1.11.3 LDH shall develop base Capitation Rates that are net of expected TPL recoveries, consistent with the Contractor's obligation under this Contract, to recover Claims paid to providers when a third party was the primary insurer.

3.1.12 Enrollment, Assignment, and Disenrollment Process

3.1.12.1 Enrollment Verification

LDH shall verify and inform the Contractor of each Enrollee's eligibility and Enrollment status with the Contractor through the State's electronic eligibility systems and through the ASC X12N 834 Benefit Enrollment and Maintenance file.

3.1.12.2 Enrollment

LDH shall:

3.1.12.2.1 Maintain sole responsibility for the Enrollment of Beneficiaries with the Contractor, as described in the *Eligibility and Enrollment* section. LDH shall present all options available to its Enrollees under the Louisiana Medicaid Program in an unbiased manner and shall inform each Enrollee at the time of Enrollment of their right to terminate Enrollment at any time;

3.1.12.2.2 Make available to the Contractor each Business Day, via the ASC X12N 834 Benefit Enrollment and Maintenance file, information pertaining to all Enrollments, including the Effective Date of Enrollment, which shall be updated each Business Day;

3.1.12.2.3 At its discretion, automatically reenroll on a prospective basis with the Contractor, Enrollees who were disenrolled from the Contractor due to loss of eligibility and whose eligibility was reestablished by LDH;

3.1.12.2.4 At its discretion, automatically assign Potential Enrollees to the Contractor based on a methodology defined by LDH;

3.1.12.2.5 Make best efforts to provide the Contractor with the most current demographic information available to LDH. Such demographic data shall include, when available to LDH, the Enrollee's

name, address, Louisiana Medicaid identification number, date of birth, telephone number, race, gender, ethnicity, and primary language; and

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

3.1.12.3 Automatic Assignment

3.1.12.3.1 LDH may automatically assign all Enrollees at the start of the Contract and shall automatically assign Potential Enrollees who do not request Enrollment in a specified MCO at the time of application for the Louisiana Medicaid Program or through the help of the Enrollment Broker, or who cannot be enrolled into the requested MCO for reasons including, but not limited to, the requested MCO having reached its Capacity or as a result of LDH-initiated sanctions. Following the initial Enrollment of Enrollees at the start of the Contract, Enrollees who fail to select a new MCO during their Enrollment period shall remain enrolled with their existing MCO. These Enrollees shall not be subject to the Automatic Assignment process.

3.1.12.3.2 In accordance with 42 CFR §438.54 the Automatic Assignment methodology shall seek to preserve existing Provider-Beneficiary Relationships during the previous year and relationships with providers that have traditionally served Beneficiaries. After consideration of Provider-Beneficiary Relationships, the methodology shall assign Beneficiaries equitably among MCOs, excluding those subject to the intermediate sanction described in 42 CFR §438.702(a)(4).

3.1.12.3.3 If the Contractor is noncompliant with the terms of this Contract, LDH may exclude the Contractor from any or all components of Automatic Assignment until the defect is cured to LDH's satisfaction. LDH shall have sole discretion to determine compliance with all such requirements and to define the period of exclusion. LDH may make such determination on a case-by-case basis and failure to exclude the Contractor from Automatic Assignment or to take any other punitive action shall not constitute ratification or approval of such noncompliance.

3.1.12.3.4 The Automatic Assignment methodology will be determined by LDH and detailed in the **MCO Manual**.

3.1.12.3.5 LDH reserves the right to adjust the Automatic Assignment algorithm to assign sufficient Potential Enrollees and Enrollees to support the viability of a new MCO. This may include, but is not limited to, the elimination of MCO linkages established under a previous contract.

3.1.12.3.6 LDH reserves the right to exclude the Contractor from the Automatic Assignment process within three (3) months prior to any termination of the Contract whether initiated by the Contractor, whether initiated by LDH, or whether at the expiration of the Contract term and any extensions.

3.1.12.4 Disenrollment

3.1.12.4.1 Disenrollment Conditions

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<#>The Enrollment Broker shall seek to preserve existing Provider-Beneficiary Relationships. If the Potential Enrollee or Enrollee has had a relationship in the previous twelve (12) months with a provider assigned to an MCO, the Potential Enrollee or Enrollee shall be assigned to that MCO. ¶
<#>If the provider is in multiple MCO networks, and if the Potential Enrollee or Enrollee has household members enrolled in an MCO in which the provider participates, the Potential Enrollee or Enrollee will be assigned to that MCO. If multiple MCO linkages exist within the household, the Potential Enrollee or Enrollee shall be assigned to the MCO in which the provider participates of the mother or head of household, if applicable, or to the MCO in which the provider participates to which a household member was most recently assigned. ¶
<#>If there is no MCO relationship within the household, the Potential Enrollee or Enrollee shall be assigned to the MCO in which the provider participates via a round robin method.¶
<#>If MCO assignment cannot be made based on existing Provider-Beneficiary Relationships, and if the Potential Enrollee or Enrollee has household members enrolled in an MCO, the Potential Enrollee or Enrollee shall be assigned to that MCO. If multiple MCO linkages exist within the household, the Potential Enrollee or Enrollee shall be assigned to the MCO of the mother or head of household, if applicable, or to the MCO to which a household member was most recently assigned. ¶
<#>If there is no previous provider relationship or household relationship, the Enrollment Broker shall use a round robin method to determine the MCO assignment.¶
<#>In addition, the Contractor's quality measures may be factored into the algorithm for Automatic Assignment, at the discretion of LDH.

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LDH shall disenroll an Enrollee from the Contractor and he or she shall no longer be eligible for MCO Covered Services through the Contractor following:

3.1.12.4.1.1 Loss of Louisiana Medicaid Program eligibility;

3.1.12.4.1.2 Completion of the Enrollee's voluntary Disenrollment request;

3.1.12.4.1.3 LDH approval in writing of a request by the Contractor for involuntary termination; or

3.1.12.4.1.4 Loss of eligibility for the Managed Care Program.

3.1.12.4.2 Except as otherwise provided under Federal law, the State Plan, or Waiver, an Enrollee may disenroll voluntarily:

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

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

3.1.12.4.2.3 Without cause, at any time during an Enrollment period.

3.1.12.4.3 Disenrollment Information

LDH shall:

3.1.12.4.3.1 Make available to the Contractor each Business Day, via the ASC X12N 834 Benefit Enrollment and Maintenance file, information pertaining to all Disenrollments, including the effective date of Disenrollment and the Disenrollment reason code; and

3.1.12.4.3.2 Provide the Contractor with information related to the reason for voluntary Disenrollment as received from Enrollees via the Enrollment Broker, on a monthly basis.

3.1.12.5 Enrollment Broker

LDH or its designee shall:

3.1.12.5.1 Develop generic materials to assist Enrollees in choosing whether to enroll with the Contractor. Said materials shall present the Contractor in an unbiased manner to Potential Enrollees. LDH may collaborate with the Contractor in developing Contractor-specific materials;

3.1.12.5.2 Present the Contractor in an unbiased manner to Enrollees who are newly eligible for the Managed Care Program or seeking to transfer from one MCO to another MCO. Such presentation(s) shall ensure that Enrollees are informed prior to enrollment of the following:

3.1.12.5.2.1 The nature of the requirements of Enrollment with the Contractor, including but not limited to:

Use of Network Providers;

Maintenance of existing relationships with Network Providers; and

The importance of Primary Care;

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

3.1.12.5.2.3 Orientation and other Enrollee services made available by the Contractor.

3.1.12.5.3 Enroll, disenroll, and process transfer requests of Enrollees, including completion of LDH's Enrollment and Disenrollment forms, except Enrollment forms for newborn Enrollees;

3.1.12.5.4 Ensure that Enrollees are informed at the time of Enrollment or transfer of their right to terminate their Enrollment voluntarily at any time, unless otherwise provided by Federal law, the State Plan, or Waiver;

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

3.1.12.5.6 At its discretion, develop and implement processes and standards to measure and improve the performance of the Enrollment Broker staff; and

3.1.12.5.7 Include all contracted MCOs in all LDH-sponsored Enrollment activities.

3.1.13 Marketing

3.1.13.1 LDH shall monitor the Contractor's Marketing activities and distribution of related materials.

3.1.13.2 Within thirty (30) Calendar Days of receipt of Marketing Material submitted by the Contractor in compliance with the *Enrollee Services* and *Marketing and Education* section, LDH shall take one of the following actions:

3.1.13.2.1 Approve or disapprove the Marketing Material;

3.1.13.2.2 Require modification to the Marketing Material; or

3.1.13.2.3 Notify the Contractor that LDH requires an additional ten (10) Business Days from the date of such notification to take the actions described above.

3.1.13.3 The Contractor shall comply with any such LDH action.

3.1.13.4 LDH's failure to take any of the actions described above within thirty (30) Calendar Days after receipt of the Contractor's Marketing Material shall be deemed to constitute approval of said Marketing Material.

3.1.13.5 If LDH has notified the Contractor that an additional ten (10) Business Days is required, LDH's failure to take approve, disapprove, or require modification in writing of the Marketing Material by the end of this ten (10) Business Day period shall be deemed to constitute approval of the Marketing Material,

3.1.13.6 LDH's failure to respond within ten (10) Business Days of receipt of modifications to Marketing Materials submitted to LDH pursuant to the above shall be deemed to constitute approval of the Marketing Material.

3.1.14 Additional Enrollee Groups and Covered Services

LDH may:

3.1.14.1 Add, delete or otherwise change mandatory, voluntary opt-out, voluntary opt-in and excluded population groups to the Contract, with sixty (60) Calendar Days advance notice to the Contractor, when possible;

3.1.14.2 Develop and implement the necessary processes and procedures required to implement Enrollment of additional Enrollee groups, as further specified by LDH;

3.1.14.3 Amend Medicaid Covered Services and modify the Contractor's MCO Covered Services required, including adding MCO Covered Services consistent with the State Plan, Waiver or other required State authorities;

3.1.14.4 Develop reimbursement rate(s) that account for the above changes to Enrollee groups or MCO Covered Services consistent with State and Federal authorities as applicable; and

3.1.14.5 Develop, in cooperation with the Contractor, an implementation strategy for providing services to Enrollees.

3.1.15 Health Needs Assessment Instrument (HNA)

3.1.15.1 LDH shall provide the Contractor with the HNA instrument, which shall include the minimum necessary set of questions to identify an Enrollee as potentially requiring case management support. The HNA will aim to identify physical, behavioral and SDOH risk factors. The required HNA may not be modified, but there will be optional screening domains that the MCOs may add, subject to LDH approval.

3.1.15.2 HNA questions shall include:

3.1.15.2.1 Enrollee demographics, personal health history, including chronic conditions and previous and current treatment for physical and behavioral health care needs, and self-perceived health status;

3.1.15.2.2 Questions to identify Enrollees' needs for culturally and linguistically appropriate services including, but not limited to, hearing and vision impairment and language preference;

3.1.15.2.3 Questions to identify the Enrollee's health concerns and goals;

3.1.15.2.4 Questions to identify potential gaps in care; and

3.1.15.2.5 Questions to identify Enrollees' health-related social needs, including housing, food insecurity, physical safety, and transportation.

3.2 Contract Non-Compliance

When LDH identifies that the Contractor is not compliant with the terms of the contract, LDH may pursue administrative actions, Corrective Action Plans, Monetary Penalties, intermediate sanctions, and/or contract termination.

3.2.1 Administrative Actions

3.2.1.1 Administrative actions exclude Monetary Penalties, Corrective Action Plans, intermediate sanctions and Contract termination and include, but are not limited to:

3.2.1.1.1 A warning through written notice or consultation;

3.2.1.1.2 Education requirement regarding program policies and procedures;

3.2.1.1.3 Review of the Contractor's business processes;

3.2.1.1.4 Referral to the Louisiana Department of Insurance for investigation;

3.2.1.1.5 Referral for review by appropriate professional organizations;

3.2.1.1.6 Referral to the Office of the Attorney General for Fraud investigation; and/or

3.2.1.1.7 Exclusion from Automatic Assignment – LDH may exclude the Contractor from any or all components of the Automatic Assignment process described in the *State Responsibilities, Contract Management* section for the duration of the noncompliance. During this period of exclusion, Enrollees shall be automatically assigned under the terms of the *State Responsibilities, Contract Management* section as if the excluded MCO were not a participant in the assignment process. Upon determining that the noncompliance has been satisfactorily cured and the thirty (30) Calendar Day minimum exclusion period has lapsed, LDH shall return the Contractor to the Automatic Assignment process but shall not take any action to return the Contractor to the position it would have been in had it not been excluded.

3.2.2 Corrective Action Plans

3.2.2.1 LDH may require the Contractor to develop a Corrective Action Plan (CAP) that includes the steps to be taken by the Contractor to obtain compliance with the terms of the Contract. A CAP is not required before LDH may pursue the application of any other non-compliance action authorized in the Contract.

3.2.2.2 LDH shall approve and monitor implementation of the CAP through available reporting resources, on-site evaluations, or requested status reports.

3.2.2.3 The CAP shall include a timeframe for anticipated compliance and a date certain for the correction of the non-compliance.

3.2.2.4 LDH may impose Monetary Penalties if the terms of the CAP are not met. Monetary Penalties shall continue until satisfactory correction of the non-compliance has been made as determined by LDH.

3.2.3 Monetary Penalties

3.2.3.1 General Information

3.2.3.1.1 Failure to comply with the requirements and performance standards set forth in this Contract may result in the assessment of a Monetary Penalty per incident and/or per Calendar Day of non-compliance. Determinations of non-compliance may be based on findings from a review of deliverables, Enrollee or provider complaints, or any other reliable source at the sole discretion of LDH.

3.2.3.1.2 The purpose of establishing and imposing Monetary Penalties is to provide a means for LDH to obtain the services and level of performance required for successful operation of the Contract. LDH's failure to assess Monetary Penalties in one or more of the particular instances described herein shall not waive the right of LDH to assess Monetary Penalties or actual damages in the future.

3.2.3.1.3 For purposes of this section, violations involving individual, unrelated acts shall not be considered as arising out of the same action.

3.2.3.1.4 Attachment G, *Table of Monetary Penalties* specifies permissible Monetary Penalties for certain violations of the Contract. For any violation not explicitly described in the table, LDH may impose a Monetary Penalty of up to five thousand dollars ($5,000) per occurrence and/or per Calendar Day.

3.2.3.1.5 LDH may, at its sole discretion, make a claim against the performance bond to satisfy Monetary Penalties imposed after contract termination.

3.2.3.2 Notices of Action and Monetary Penalty

3.2.3.2.1 LDH may first notify the Contractor of incidents of non-compliance and of LDH's authority to impose a Monetary Penalty via a Notice of Action (NOA). The NOA will include the basis and nature of the violation, the relevant contract sections and/or provisions of law, the deadline

to cure the violation, if applicable, and the methodology for calculation of any Monetary Penalty if the violation is not cured by the established deadline, if applicable.

3.2.3.2.2 Monetary Penalties may be assessed against the Contractor at the sole discretion of LDH, regardless of whether an NOA is issued. LDH will notify the Contractor of the assessment of Monetary Penalties via a Notice of Monetary Penalty (NOMP).

3.2.3.2.3 LDH may require the Contractor to provide a written response with a detailed explanation of the reasons for the violation, the Contractor's assessment or diagnosis of the cause, and Contractor's plan to address or cure the deficiency within the timeframe set forth in the NOA or NOMP.

3.2.3.2.4 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 LDH may have at law.

3.2.3.2.5 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.

3.2.4 Intermediate Sanctions

3.2.4.1 Acts or Failures to Act Subject to Intermediate Sanctions

Pursuant to 42 CFR §438.700, LDH may impose on the Contractor intermediate sanctions if it determines that the Contractor:

3.2.4.1.1 Fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under the Contract, to an Enrollee covered under the Contract;

3.2.4.1.2 Imposes on Enrollees premiums or charges that are in excess of the premiums or charges permitted under the Managed Care Program;

3.2.4.1.3 Acts to discriminate among Enrollees on the basis of their health status or need for health care services. This includes termination of Enrollment, refusal to reenroll an Enrollee, except as permitted in the *Eligibility and Enrollment* section, or any practice that would reasonably be expected to discourage Enrollment by Beneficiaries whose medical condition or history indicates probable need for substantial future medical services;

3.2.4.1.4 Misrepresents or falsifies information that it furnishes to CMS or to LDH;

3.2.4.1.5 Misrepresents or falsifies information that it furnishes to an Enrollee, Potential Enrollee, or a health care provider;

3.2.4.1.6 Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR §438.3(i), §422.208, and §422.210;

3.2.4.1.7 Distributes directly, or indirectly through any agent or independent contractor, Marketing Materials that have not been approved by LDH in writing or that contain false or materially misleading information; or

3.2.4.1.8 Violates any of the other applicable requirements of 42 U.S.C. §1396b(m), §1396d(t)(3), or §1396u-2 and any implementing regulations.

3.2.4.2 Other Misconduct Subject to Intermediate Sanctions

LDH also may impose sanctions against the Contractor if it finds any of the following non-exclusive actions/occurrences:

3.2.4.2.1 The Contractor has failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from LDH;

3.2.4.2.2 The Contractor has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to the Medicare-Medicaid Anti-Fraud and Abuse Amendments, Public Law 95-142;

3.2.4.2.3 The Contractor or any of its owners, officers or directors has been convicted of a criminal offense relating to performance of the Contract with LDH or of fraudulent billing practices or of negligent practice resulting in death or injury to the Contractor's Enrollee;

3.2.4.2.4 The Contractor has presented, or has caused to be presented, any false or fraudulent Claim for services or has submitted, or has caused to be submitted, false information to be furnished to the State or the Secretary of HHS;

3.2.4.2.5 The Contractor has engaged in a practice of charging and accepting payment (in whole or part) from Enrollees for services for which a PMPM payment was made by LDH;

3.2.4.2.6 The Contractor has rebated or accepted a fee or portion of fee or charge for a patient referral;

3.2.4.2.7 The Contractor has failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments;

3.2.4.2.8 The Contractor has failed to keep or make available for inspection, audit or copying, such records regarding payments claimed for providing services;

3.2.4.2.9 The Contractor has failed to furnish any information requested by LDH regarding payments for providing goods or services;

3.2.4.2.10 The Contractor has made, or caused to be made, any false statement or representation of a material fact to LDH or CMS in connection with the administration of the Contract; or

3.2.4.2.11 The Contractor has furnished goods or services to an Enrollee which at the sole discretion of LDH, and based on competent medical judgment and evaluation are determined to be 1) insufficient for his or her needs, 2) harmful to the Enrollee, or 3) of grossly inferior quality.

3.2.4.3 Sanction Types

The types of intermediate sanctions that LDH may impose on the Contractor shall be in accordance with 42 U.S.C. §1396u-2 and 42 CFR §§438.702 - 438.708 and may include any of the following:

3.2.4.3.1 Civil Monetary Penalties in the amounts specified in 42 CFR §438.704;

3.2.4.3.2 Appointment of temporary management for the Contractor as provided in 42 CFR §438.706;

3.2.4.3.3 Granting Enrollees the right to terminate Enrollment without cause and notifying the affected Enrollees of their right to disenroll;

3.2.4.3.4 Suspension of all new Enrollments, including Automatic Assignment, after the effective date of the sanction and for a time period determined by LDH;

3.2.4.3.5 Suspension of payment for Enrollees enrolled after the effective date of the sanction and until CMS or LDH is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; and

3.2.4.3.6 Additional sanctions allowed under State laws, regulations, rules, and policies that address areas of noncompliance described above.

3.2.4.3.7 LDH may require the Contractor to develop a Corrective Action Plan, as described in this section, to address areas of non-compliance subject to intermediate sanctions.

3.2.4.3.8 Except as provided in this section, before imposing any intermediate sanctions, LDH shall give the Contractor Timely written notice that explains the basis and nature of the sanction and any other due process protections.

3.2.4.4 Notice to CMS

LDH shall give the CMS Regional Office written notice whenever it imposes or lifts an intermediate sanction for one of the violations listed in 42 CFR §438.700, specifying the affected MCO, the kind of sanction, and the reason for LDH's decision to impose or lift a sanction. Notice will be given no later than thirty (30) Calendar Days after LDH imposes or lifts the sanction.

3.2.5 Disputes and Appeals

3.2.5.1 If LDH chooses to notify the Contractor of incidents of non-compliance and of LDH's authority to impose a Monetary Penalty or other administrative action via a NOA prior to assessing the penalty or action, the Contractor may dispute infractions contained within the NOA through the following process:

3.2.5.1.1 Within fourteen (14) Calendar Days after receipt of the NOA, the Contractor shall submit its dispute of the NOA directly to the Medicaid Deputy Director or his/her designee in writing via e-mail; this submission shall include all arguments, materials, data, and information necessary to resolve the dispute.

3.2.5.1.2 The Contractor shall waive any dispute or argument not raised within fourteen (14) Calendar Days of receiving the NOA. The Contractor shall also waive the right to use any materials, data, and/or information not contained in or accompanying the Contractor's submission submitted

within the fourteen (14) Calendar Days following its receipt of the NOA in any subsequent NOMP issued should the Contractor fail to demonstrate compliance as stated in the NOA.

3.2.5.1.3 The Medicaid Deputy Director or his/her designee will decide the dispute, reduce the decision to writing, and provide a copy to the Contractor. This written decision will be final.

3.2.5.2 To appeal the assessment of a Monetary Penalty or intermediate sanction:

3.2.5.2.1 Within seven (7) Business Days of receipt of the NOMP, the Contractor shall submit its appeal in writing to the Medicaid Deputy Director or his/her designee. LDH will issue a written decision within fifteen (15) Business Days of the appeal.

3.2.5.2.2 Within five (5) Business Days of receipt of LDH's written decision, the Contractor may request reconsideration of the decision in writing to the Medicaid Executive Director. The Medicaid Executive Director shall issue a written opinion within thirty (30) Calendar Days. No further appeals to LDH shall be allowed.

3.2.6 Payment of Monetary Penalties and Intermediate Sanctions

3.2.6.1 Monetary Penalties or intermediate sanctions assessed by LDH that cannot be collected through the capitated payment deduction specified in the *Payment and Financial Provisions, Return of Funds* section shall be due and payable to LDH within thirty (30) Calendar Days after the Contractor's receipt of the notice of Monetary Penalties or sanctions.

3.2.6.2 The assessment of Monetary Penalties or intermediate sanctions shall not be halted by the disputes and appeals process. In the event an appeal by the Contractor results in a decision in favor of the Contractor, the penalty/sanction amount specified in the decision shall be returned to the Contractor.

3.2.6.3LDH has the right to recovery of any amounts overpaid as the result of deceptive practices by the Contractor and/or its Subcontractors, and may consider trebled damages, civil penalties, and/or other remedial measures.

3.2.6.4A Monetary Penalty or sanction may be applied to all known Affiliates, subsidiaries and parents of the Contractor, provided that each decision to include an Affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the Contractor is affiliated when such conduct was accomplished within the course of his official duty or was effectuated by him with the knowledge or approval of such person.

3.2.7 Termination of MCO Contract

3.2.7.1 Nothing in this Section shall limit LDH's right to terminate the Contract or to pursue any other legal or equitable remedies.

3.2.7.2 Pursuant to 42 CFR §438.708, LDH may terminate the Contract and enroll that Contractor's Enrollees in other MCOs or provide their benefits through other options included in the State Plan if LDH, at its sole discretion, determines that the Contractor has failed to: (1) carry out the substantive terms of the Contract, or (2) meet applicable requirements in 42 U.S.C. §1396b(m), §1396d(t), or §1396u-2.

3.2.7.3 LDH shall provide the Contractor with a Timely written Notice of Intent to Terminate (Notice) that states the nature and basis of the termination and pre-termination hearing rights.

3.2.7.4 The termination shall be effective no less than thirty (30) Calendar Days from the date of the Notice of Intent to Terminate. The Contractor may, at the discretion of LDH, be allowed to correct the deficiencies within the thirty (30) Calendar Day notice period, unless other provisions in this Section demand otherwise, prior to the issuance of a Notice of Termination.

3.2.7.5 In accordance with 42 CFR §438.710, LDH shall conduct a pre-termination hearing as outlined in the Notice of Intent to Terminate to provide the Contractor the opportunity to contest the nature and basis of the sanction.

3.2.7.6 The Contractor shall receive a written notice of the outcome of the pre-termination hearing, if applicable, indicating decision reversal or affirmation.

3.2.7.7 The decision by the LDH Undersecretary shall be final and the Administrative Procedure Act, La. R.S. 49:950, et seq., does not apply. The Notice of Termination will state the effective date of termination.

3.2.7.8 LDH shall notify the Enrollees enrolled in the Contractor in writing, consistent with 42 CFR §438.710 and §438.722, of the affirming termination decision and of their options for receiving Medicaid Covered Services and their right to disenroll immediately without cause.

3.2.8 Payment of Outstanding Monies or Collections from the Contractor

The Contractor shall be paid for any outstanding monies due less any assessed Monetary Penalties or sanctions. If Monetary Penalties exceed monies due, collection may be made from the Contractor Fidelity Bond, Performance Bond, Retainage, Errors and Omissions Insurance, or any insurance policy or policies required under this Contract. The rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

3.2.9 Provider Sanctions

Nothing contained herein shall prohibit LDH from imposing sanctions, including, but not limited to, civil Monetary Penalties, license revocation, and Louisiana Medicaid Program

termination, upon a health care provider for its violations of Federal or State law, rule, or regulations.

3.2.10 Independent Assurances

3.2.10.1 When required by LDH, the Contractor shall provide a quality control plan, such as third party Quality Assurance (QA), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits.

3.2.10.2 These audits shall require the Contractor to provide any assistance, records access, information system access, staff access, and space access to the party selected to perform the independent audit. The audit firm will submit to the Department and/or Contractor a final report on controls placed in operations for the project and includes a detailed description of the audit firm's tests of the operating effectiveness of controls.

3.2.10.3 The Contractor shall supply the LDH with an exact copy of the report within thirty (30) Calendar Days of completion. When required by LDH, such audits may be performed annually during the term of the Contract. The Contractor shall agree to implement recommendations as suggested by the audits within three (3) months of report issuance at no cost to the State. The cost of the audit is to be borne by the Contractor.

PART 4: PAYMENT AND FINANCIAL PROVISIONS

4.1 Capitated Payments

4.1.1 LDH shall make monthly Capitation Payments to the Contractor based on its Enrollment for the month.

4.1.2 Enrollment for the month is determined by the total number of Enrollees linked to the Contractor as of the first (1st) Calendar Day of the month, with Capitation Payments due in the following month. For age group assignment purposes, age shall be determined as of the first (1st) Calendar Day of the month for which the payment is intended.

4.1.3 LDH may make Capitation Payments on a lump sum basis when administratively necessary.

4.2 Maternity Kick Payments

4.2.1 LDH shall provide the Contractor with a one-time supplemental lump sum payment for each obstetrical delivery. This maternity Kick Payment is intended to cover the cost of prenatal care, the delivery event, postpartum care, and uncomplicated newborn hospital costs.

4.2.2 Maternity Kick Payments may be differentiated between early elective delivery events (deliveries occurring before thirty-nine (39) weeks without a medical indication) and all other delivery events. The amount of maternity Kick Payments shall be determined by LDH's actuary.

4.2.3 Only one (1) maternity Kick Payment shall be made per delivery event. Multiple births during the same delivery shall result in one (1) maternity Kick Payment being paid. The maternity Kick Payment shall be paid for both live and still births. A maternity Kick Payment shall not be paid for abortions or spontaneous abortions (as defined in State law).

4.2.4 The maternity Kick Payment shall be paid to the Contractor upon submission of satisfactory evidence of the occurrence of a qualifying delivery.

4.3 MCO Payment Schedule

4.3.1 Capitated payments and maternity Kick Payments shall be made in accordance with the payment schedule established by LDH and published on the Fiscal Intermediary (FI) website.

4.3.2 LDH reserves the right to defer remittance of the monthly Capitation Payment scheduled for June until the first (1st) payment cycle in July to comply with State fiscal policies and procedures.

4.3.3 Any incentive payments made by LDH shall be made in accordance with the timeline established in Approved Incentive Arrangements and the MCIP protocol.

4.4 Financial Incentives for MCO Performance

4.4.1 MCO Performance Withhold Amount

4.4.1.1 LDH may withhold a portion of the Contractor's monthly Capitation Payments to incentivize quality and health outcomes. The withhold amount will be equal to three percent (3%) of the monthly Capitation Payments for integrated physical and behavioral health for all Enrollees, exclusive of maternity Kick Payments, payments under the Managed Care Incentive Program, and directed payment arrangements.

4.4.1.2

4.4.1.3 No interest shall be due to the Contractor on any sums withheld or retained under this Section.

4.4.1.4 The withhold arrangement is for a fixed period of time and performance is measured during the rating period under the contract in which the withhold arrangement is applied. Withhold arrangements shall not be renewed automatically. Withhold arrangements are available to both public and private contractors under the same terms of performance. Participation in withhold arrangements is not conditioned on the Contractor entering into or adhering to intergovernmental transfer agreements.

4.4.1.5 The withhold arrangement is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy under 42 CFR §438.340.

4.4.1.6 The provisions of this Section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under this Contract. LDH reserves the right to assess Monetary Penalties for failure to meet deliverables as required under this Section.

4.4.1.7

4.4.2 Earning the Quality and Health Outcomes Withhold

4.4.2.1 For each Measurement Year, the Contractor may earn back the applicable quality withhold based on its performance relative to incentive-based measures and targets as established by LDH for that Measurement Year.

4.4.2.2 Performance measure descriptions and targets for incentive-based measures will be specified in Attachment H, *Quality Performance Measures*, prior to the start of the Measurement Year. Incentive-Based (IB) measures are identified in Attachment H, *Quality Performance Measures*, annotated with "$$."

4.4.2.3 Targets for Healthcare Effectiveness Data and Information Set (HEDIS®) incentive-based measure scores will be equal to or above the National Committee for Quality Assurance (NCQA) Quality Compass Medicaid National 50th percentile [All Lines of Business (LOBs) (Excluding Preferred

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Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs))] values for the prior Quality Compass product Year.

4.4.2.4 Targets for HEDIS® incentive-based measure scores without a NCQA Quality Compass Medicaid National 50th percentile [All Lines of Business (LOBs) (Excluding Preferred Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs))] value will be equal to the best performance reported to LDH by any MCO for the Measurement Year that is two (2) years prior to the current Measurement Year.

4.4.2.5 If NCQA makes changes to any of the measures selected by LDH, such that valid comparison to prior Measurement Years will not be possible, or if it is determined that a measure is not reasonably attainable, LDH, at its sole discretion, may elect to eliminate the measure from incentive eligibility, change the affected measure to be reporting only, or replace it with another measure.

4.4.2.6 Targets for non-HEDIS incentive-based measures shall be equal to the best performance reported to LDH by any MCO for the Measurement Year that is two (2) years prior to the current Measurement Year.

4.4.2.7 LDH shall determine the amount of the quality withhold earned back by the Contractor based on the Contractor's performance on the incentive-based measures.

4.4.2.8 All incentive-based measures shall be weighted equally for purposes of the Contractor earning back the quality withhold, unless otherwise specified by LDH prior to the Measurement Year.

4.4.2.9 To earn back the full withhold amount associated with each incentive-based measure, Contractor performance must either meet the LDH-specified target for that measure or improve over the Contractor's performance for that measure for the prior Measurement Year by at least two (2) points (2.0 without any rounding). If the Contractor did not report data for a particular measure in accordance with LDH requirements for the prior Measurement Year, or if comparable data is not available for any specific incentive-based measure in the prior Measurement Year, as determined by LDH, the Contractor shall meet the target to earn the withhold for this measure.

4.4.2.10 If the Contractor submits its HEDIS results to NCQA per the timelines and specifications as required in the *Quality Management and Quality Improvement* section, along with proof of submission to LDH, LDH shall refund five (5) months of the Contractor's estimated withheld funds for quality and health outcomes for the Measurement Year for which the results are reported, provided that the unaudited results indicate that the Contractor is meeting or exceeding the benchmark or performance improvement targets for more than half of the incentive-based measures.

4.4.2.11 Non-HEDIS incentive-based measure scores shall be calculated by LDH and compared to targets established by LDH.

4.4.2.12 For all measures, the Contractor's results shall be validated by LDH's contracted External Quality Review Organization (EQRO) and outcomes research & evaluation contractor.

4.4.2.13 No later than the end of the calendar year of the reporting year, LDH shall notify the Contractor of the amount of its quality withhold earned back and refund the amount within thirty (30) Calendar Days of such notice.

4.4.2.14 LDH shall retain the amount of the quality withhold not earned back by the Contractor.

4.4.3 Earning the VBP Withhold

For Calendar Year 2025, the Contractor may earn back the applicable VBP withhold based on meeting the VBP reporting and performance requirements and targets for that Measurement Year as established by this Contract including as described in the *Value-Based Payment* section.

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4.4.3.1 The Contractor may earn back the VBP withhold amount for submitting VBP deliverables and meeting VBP targets specified by LDH as demonstrated within the Contractor's reported use of VBP consistent with the HCP-LAN APM Framework and VBP requirements of this Contract.

4.4.3.2 The VBP Measurement Year is the calendar year. To earn back the full VBP withhold amount related to performance for each Measurement Year, the Contractor shall:

4.4.3.2.1 Annually, on or before August 30, submit to LDH a written VBP mid-year report describing the implementation and status of its VBP use and evidence that each VBP model includes financial incentives for providers linked to at least two of the Contractor's incentive-based measures in Attachment H, *Quality Performance Measures*, or other Attachment H, *Quality Performance Measures*, measures for non-primary care VBP arrangements.

4.4.3.2.1.1 To increase simplification and consistency in provider performance data reporting, the Contractor must use performance measure specifications in its VBP arrangements that align with the LDH specifications for measures in Attachment H, *Quality Performance Measures* when the Contractor is utilizing any measure included in Attachment H, *Quality Performance Measures*.

4.4.3.2.2 Annually, on or before March 15, submit to LDH a report on its VBP use for the prior calendar year as specified in Attachment E, *APM Reporting Template*, and a VBP year-end report. In reporting its VBP use and provider payments, the Contractor shall use a "date of payment" approach to complete Attachment E, *APM Reporting Template*. If the Contractor did not meet the VBP targets identified in 4.4.3.2.4, if applicable, the Contractor shall describe why the VBP targets were not met.

Deleted: <#>If LDH determines that the mid-year report demonstrates VBP use by the Contractor that includes applicable performance measures in Attachment H, *Quality Performance Measures*, and is consistent with LDH specifications in this Contract, LDH will refund a portion of the VBP-related amounts withheld for the calendar year prior to the end of the calendar year. The VBP withhold amounts shall not be refunded for late submissions.

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4.4.3.2.3

4.4.3.2.3.1 Calendar Year 2025 and Future Calendar Years

Contractual arrangements linked to a VBP model account for at least sixty percent (60%) of total provider payments, and the Contractor's total provider incentive payments exceed eight (8) million dollars, or the Contractor's total provider incentive payments exceed sixteen (16) million dollars.

The Contractor's VBP models must include at least one (1) new provider contract with a category 3A APM, one (1) new provider contract with a category 3B APM, and one new provider contract with a category 4 APM that is effective no later than the end of the applicable calendar year.

The Contractor must submit an annual report demonstrating how its VBP models align with LDH Contractor incentive-based and other contractual performance measures.

The Contractor must analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will use the results of this data analysis to improve VBP models and provider support for future calendar years.

For Calendar Year 2025, LDH may refund to the Contractor some of the remaining amounts withheld for VBP if the Contractor partially meets the applicable VBP targets in 4.4.3.2.4 and describes to LDH's satisfaction why the Contractor did not fully meet the VBP targets.

For Calendar Year 2025, LDH shall retain the amount of the VBP withhold not earned back by the Contractor.

4.4.3.2.4 The Contractor must develop a multi-year Health Equity Plan and submit the finalized plan thirty (30) Calendar Days after the Operational Start Date. The Contractor's Health Equity Plan must include:

4.4.3.2.4.1 Stratify Contractor results on certain quality measures to identify/address disparities.

4.4.3.2.4.2 Include staff/provider training requirements related to equity, beyond CLAS requirements.

4.4.3.2.4.3 Include social needs/equity questions in Health Needs Assessment and develop mechanisms to close the referral loop to act on identified social risk factors.

4.4.3.2.4.4 Engage a variety of Enrollees/populations in the Contractor's health equity approach.

4.4.3.2.5 The Contractor must submit updates to the Health Equity Plan twice per year by July 31 and December 31.

4.4.3.2.5.1 The mid-year report must include a status update on progress made on health equity strategies submitted with the initial plan.

4.4.3.2.5.2 The annual report submitted to LDH by December 31 must demonstrate progress on meeting Health Equity milestones and goals as outlined in Section 2.6 of the Contract.

Deleted: If LDH determines that the Contractor's use of recognized VBP models meets the following VBP targets in each specific calendar year as described below, LDH will refund any remaining amounts withheld for VBP. Recognized VBP arrangements exclude certain LAN APM category 2A and 2B models and VBP models that do not have a link to at least two of the applicable Contractor performance measures in Attachment H, *Quality Performance Measures,* as defined in the *Value-Based Payment* sections of this Contract.

Deleted: <#>Unless otherwise modified by LDH, the minimum VBP thresholds for each Measurement Year are as follows:¶
<#>Calendar Year 2023¶
<#>Contractual arrangements linked to a VBP model that includes one (1) or more of the HCP LAN categories identified by LDH account for at least forty percent (40%) of total provider payments in the Measurement Year and the Contractor's total provider incentive payments related to this Measurement Year exceed six (6) million , OR the Contractor's total provider incentive payments exceed twelve (12) million dollars.¶
<#>The Contractor's VBP models must include at least one (1) new provider contract with a category 3A APM, category 3B APM or category 4 APM that is effective no later than December 2023.¶
<#>The Contractor must submit an annual report demonstrating how its VBP models align with LDH Contractor incentive-based and other contractual performance measures and provide initial data-based assessments to determine the extent to which providers participated in specific VBP models may be performing differently on targeted quality measures than providers not participating in such VBP models. ¶
<#> Calendar Year 2024¶
<#>Contractual arrangements linked to a VBP model account for at least fifty percent (50%) of total provider payments in the Measurement Year and the Contractor's total provider incentive payments related to this Measurement Year exceed seven (7) million dollars, or the Contractor's total provider incentive payments exceed fourteen (14) million dollars. ¶
<#>The Contractor's VBP models must include at least one (1) new provider contract with a category 3A APM ...

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Deleted: <#>Earning Health Equity Withhold¶
<#>For each Measurement Year, the Contractor may earn back the applicable Health Equity withhold based on its reporting and performance relative to Health Equity requirements for that Measurement Year as established by this Contract and LDH as described in the *Health Equity* section.¶ ...

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4.4.3.3 LDH shall retain the amount of the Health Equity withhold not earned back by the Contractor.

4.4.4 Other Requirements Related to Quality

4.4.4.1 If, in the final determination of Contractor performance relative to Quality and Health Outcomes, the Contractor's unearned withhold amount exceeds its withhold balance held in escrow by LDH, the Contractor is responsible for remitting payment for the balance to LDH within thirty (30) Calendar Days following notification to the Contractor 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.

4.4.4.2 If the Contractor is unable to achieve specified milestones required to earn back the withhold, solely due to an early termination for convenience, LDH shall refund the remainder of the amount withheld.

4.4.4.3 All MCOs contracted with LDH shall utilize the collectively agreed upon common format and frequency for provider-specific profile reports on the incentive-based quality measures identified in Attachment H, *Quality Performance Measures*. The profile format shall be reviewed annually by the MCOs. Any revisions shall be reviewed and approved by LDH at least thirty (30) Calendar Days prior to implementation.

4.4.4.4 The Contractor shall distribute provider-specific profile reports to providers using the common format and frequency effective the first quarter of calendar year 2023, as approved by LDH in writing.

4.4.4.5 No interest shall be due to the Contractor on any sums withheld or retained under this Section.

4.4.4.6 The withhold arrangement is for a fixed period of time and performance is measured during the rating period under the contract in which the withhold arrangement is applied. Withhold arrangements are available to both public and private contractors under the same terms of performance. Participation in withhold arrangements is not conditioned on the Contractor entering into or adhering to intergovernmental transfer agreements.

4.4.4.7 The withhold arrangement is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy under 42 CFR §438.340.

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

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LDH reserves the right to assess Monetary Penalties for failure to meet deliverables as required under this section.

4.5 Medical Loss Ratio

4.5.1 In accordance with the **MCO Financial Reporting Guide** and 42 CFR §438.8, the Contractor shall provide a Medical Loss Ratio (MLR) report for each MLR reporting year, which shall align with the capitation rating period, except in circumstances in which the MLR reporting period must be revised to align to a CMS-approved capitation rating period.

4.5.2 The MLR shall be reported in the aggregate, unless LDH requires separate reporting and separate MLR calculations for specific populations.

4.5.3 If the aggregate MLR or the MLR for any specific population is less than eighty-five percent (85%), the Contractor shall refund LDH the difference. Any unpaid balances after the refund is due shall be subject to interest at the current Federal funds rates plus three percent (3%) or ten percent (10%) annually, whichever is higher.

4.5.4 LDH may request MLR reporting that distinguishes physical and basic behavioral health from specialized behavioral health.

4.5.5 The Contractor and its Subcontractors shall retain MLR reports for a period of no less than ten (10) years following termination of the Contract.

4.6 Payment Adjustments

4.6.1 In the event that an erroneous payment is made to the Contractor, LDH shall reconcile the error by adjusting the Contractor's next monthly Capitation Payment or future Capitation Payments on a schedule determined by LDH in consultation with the FI.

4.6.2 Retrospective adjustments to prior Capitation Payments shall occur when it is determined that an Enrollee's aid category and/or type case was changed and the Enrollee remains eligible for the Managed Care Program.

4.6.3 If an Enrollee is moving from an aid category and/or type case that is eligible for managed care to an aid category and/or type case that is not eligible for managed care, the previous Capitation Payments for excluded months will be recouped from the Contractor. The Contractor shall initiate recoupments of payments to providers within sixty (60) Calendar Days after the end of the month in which LDH notifies the Contractor of the change. The Contractor shall instruct the provider to resubmit the Claim(s) to FFS (if applicable).

4.6.4 In cases of a retroactive effective date for Medicare Enrollment of an Enrollee, the Contractor shall recoup payments made to the providers in accordance with the *Post-Payment Recoveries* section of this Contract. The Contractor shall initiate recoupments within sixty (60) Calendar Days after the end of the month in which LDH notifies the Contractor of Medicare Enrollment. The Contractor shall instruct the provider to resubmit the Claim(s) to Medicare.

4.6.5 Capitation Payments received from LDH for a deceased Enrollee after the month of death and for an incarcerated Enrollee the month after entering involuntary custody shall be recouped by LDH.

4.6.6 For Enrollees who are disenrolled due to the invalidation of a duplicate Medicaid ID Number, the Contractor shall not recover Claim payments under the retroactively dis-enrolled Medicaid ID Number if the remaining valid Medicaid ID Number is linked to another MCO. The Contractor shall subrogate the amount of the paid Claim(s) to the MCO that is responsible for the Claim(s) for the dates of service.

4.6.7 The entire monthly Capitation Payment shall be paid for the month of birth, month of death, and month of entry into involuntary custody. Capitation Payments shall not be prorated to adjust for partial month eligibility as this has been factored into the actuarial rates.

4.7 Risk Sharing

4.7.1 The Contractor shall agree to accept, as payment in full, the monthly Capitation Payment and maternity Kick Payment established by LDH pursuant to the Contract, and shall not seek additional payment from an Enrollee, or LDH, for any unpaid cost except as allowed by the Cost Sharing requirements of this Section.

4.7.2 The Contractor shall assume one hundred percent (100%) liability for any expenditure above the monthly Capitation Payment and maternity Kick Payment.

4.7.3 LDH will maintain a risk corridor for Hepatitis C-related pharmacy, physician, and laboratory costs. The parameters of this risk corridor and process for reconciliation and payments will be specified in the **Financial Reporting Guide**.

4.7.3.1 The Contractor will be fully at risk for gains or losses less than or equal to one percent (1%) of the aggregate Hepatitis C-related medical component of the risk-adjusted capitation payment.

4.7.3.2 The Contractor and LDH will share risk for gains and losses greater than one percent (1%) of the aggregate Hepatitis C-related medical component of the risk-adjusted capitation payment.

4.7.3.2.1 The Contractor share of risk will be one percent (1%).

4.7.3.2.2 The LDH share of the risk will be ninety-nine percent (99%).

4.7.4 High-Cost Drug Risk Pool Arrangement

The amount of the high-cost drug risk pool, if applicable, will be determined by the projected utilization and cost per service of these drugs during the rating year and will be incorporated into annual Capitation Rates as described in the rate certification. LDH will redistribute funds among MCOs based on the methodology determined by the State's contracted actuary and described in the rate certification. The high-cost drug risk pool will be settled following the conclusion of the annual contract period.

4.8 Determination of Capitation Rates

4.8.1 LDH shall develop actuarially sound Capitation Rates in accordance with 42 CFR §§438.4 - 438.7 and all applicable Federal rules and regulations. LDH shall not use a competitive bidding process to develop the Capitation Rates. LDH shall develop Capitation Rates that will be offered to MCOs. The Capitation Rates are not negotiable.

4.8.2 Capitation Rates shall be set using Encounter Data, financial data, and supplemental ad hoc data and analyses appropriate for determining actuarially sound Capitation Rates. Fiscal periods of the base data shall be determined based upon the data sources, rate periods, and purposes for which the data is used with appropriate adjustments, including the following:

4.8.2.1 Utilization trend and the expected impact of managed care on the utilization of the various types of services applied to varying sources of data, including managed care savings assumptions and managed care efficiency adjustments.

4.8.2.2 Unit cost trend and assumptions regarding managed care pricing and payments.

4.8.2.3 Third Party Liability (TPL) recoveries.

4.8.2.4 The expected cost of MCO administration and overhead, including but not limited to premium taxes.

4.8.3 Additional factors determining the Capitation Rate for an Enrollee may include: 1) age; 2) gender; 3) Louisiana Medicaid Program category of assistance; 4) the geographic location of the Enrollee's residence; and 5) Medicare Enrollment.

4.8.4 The Contractor shall be paid in accordance with the Capitation Rates specified in Attachment D, *Actuarial Rate Certification Letter*, of this Contract.

4.8.5 The rates shall be reviewed and may be periodically adjusted. Any adjusted Capitation Rates shall be actuarially sound, consistent with requirements set forth in 42 CFR §§438.4 - 438.7, and will require an amendment to the Contract.

4.8.6 LDH reserves the right to adjust the Capitation Rates in the following instances:

4.8.6.1 Changes to MCO Covered Services included in the Capitation Rates;

4.8.6.2 Changes to Louisiana Medicaid Program populations eligible to enroll in the Managed Care Program;

4.8.6.3 Legislative appropriations and budgetary constraints; or

4.8.6.4 Changes in Federal requirements.

4.8.7 The Contractor shall provide, in writing, any information requested by LDH to assist in the determination of Capitation Rates. LDH shall give the Contractor reasonable time to respond to the

request and full cooperation by the Contractor is required. LDH shall make the final determination as to what is considered reasonable time.

4.8.8 LDH shall utilize overpayment and recovery data in calculating future Capitation Rates per 42 CFR §438.608(d)(4).

4.9 Risk Adjustment

4.9.1 Capitation Payments for integrated physical and behavioral health shall be risk-adjusted as deemed appropriate by LDH.

4.9.1.1 LDH shall analyze the risk profile of the Contractor's Enrollees using a national risk adjustment model specified by the State.

4.9.1.2 Each Enrollee shall be assigned to risk categories based on factors appropriate for the risk adjustment model. This information and the relative cost associated with each risk category reflects the anticipated utilization of health care services relative to the overall population.

4.9.1.2.1 The relative costs shall be developed using Louisiana specific historical data from FFS Claims and Encounter Data as determined appropriate.

4.9.1.3 The relevant portions of the Contractor's proposed base Capitation Rates shall be risk adjusted based on the Contractor's risk score that reflects the expected health care expenditures associated with its Enrollees relative to the applicable total Louisiana Medicaid Program population.

4.9.1.4 When practical, LDH shall notify the Contractor in advance of any major revision to the risk adjustment methodology that differs from the methodology used for the prior risk adjustment update. The Contractor shall be given fourteen (14) Calendar Days from the date of the notice to provide input on the proposed changes. LDH shall consider the feedback received from the Contractor when implementing changes to the risk adjustment methodology, but has final decision-making authority.

4.9.2 Certain Capitation Payments may not be risk-adjusted based on considerations of how such payments were developed and the availability of risk adjustment data.

4.10 Return of Funds

4.10.1 All amounts owed by the Contractor to LDH, as identified through routine or investigative reviews of records or audits conducted by LDH or other State or Federal agency, as well as Monetary Penalties levied against the Contractor for Contract non-compliance, may be deducted from the monthly Capitation Payment upon notification by LDH.

4.10.2 Amounts that exceed or cannot otherwise be collected through the Capitation Payment deduction shall be due and payable to LDH no later than thirty (30) Calendar Days following notification to the Contractor by LDH, unless otherwise authorized in writing by LDH. LDH reserves the right to accrue and collect interest on unpaid balances beginning thirty (30) Calendar Days from

the date of initial notification. Any unpaid balances that remain after the refund is due shall be subject to interest at the current Federal funds rate plus three percent (3%) or ten percent (10%) annually, whichever is higher.

4.10.3 The Contractor shall reimburse LDH for any Federal disallowances or sanctions imposed on LDH as a result of the Contractor's failure to abide by the terms of the Contract. The Contractor shall be subject to any additional conditions or restrictions placed on LDH by HHS as a result of the disallowance. Instructions for returning of funds shall be provided by written notice.

4.11 Other Payment Terms

4.11.1 The Contractor shall make payments to its providers as stipulated in the Contract.

4.11.2 The Contractor shall not assign its right to receive payment to any other entity without written consent of LDH. Notice of any such assignment or transfer shall be promptly furnished to the Division of Administration, Office of State Procurement.

4.11.3 Payment for items or services provided under this Contract will not be made to any entity located outside of the United States.

4.11.4 The Contractor shall agree to accept payments as specified in this Section and have written policies and procedures for receiving and processing payments and adjustments. Any charges or expenses imposed by financial institutions for transfers or related actions shall be borne by the Contractor.

4.11.5 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 Contractor 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 Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the State paid the Contractor 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 Contractor 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 Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

4.12 Cost Sharing

4.12.1 The Contractor and its Subcontractors are not required to impose any Copayments or Cost Sharing requirements on Enrollees.

4.12.2 The Contractor and its Subcontractors may impose Cost Sharing on Enrollees in accordance with 42 CFR §447.50 - 447.82 provided that it does not exceed Cost Sharing amounts in

the State Plan. The Copayment tiers in the State Plan shall be based on the total amount reimbursed to the pharmacy for the Claim.

4.12.3 The Contractor shall ensure Cost Sharing incurred by all individuals in the Louisiana Medicaid Program household does not exceed an aggregate limit of five percent (5%) of the household's income applied on a quarterly or monthly basis as instructed by LDH.

4.12.4 LDH reserves the right to amend Cost Sharing requirements.

4.12.5 The Contractor and its Subcontractors may not:

4.12.5.1 Deny services to an Enrollee who is eligible for services because of the Enrollee's inability to pay the Cost Sharing.

4.12.5.2 Restrict Enrollees' access to needed drugs and related pharmaceutical products by requiring Enrollees to use mail-order pharmacy providers.

4.12.5.3 Impose Copayments for services specified in the **MCO Manual**.

4.13 Third Party Liability

4.13.1 General TPL Information

4.13.1.1 Pursuant to Federal and State law, the Louisiana Medicaid Program is intended to be the payer of last resort. This means all other liable third parties must meet their legal obligation to pay Claims before the Contractor pays for the care of an Enrollee.

4.13.1.2 The Contractor shall take reasonable measures to determine TPL.

4.13.1.3 The Contractor shall coordinate benefits in accordance with 42 CFR Part 433, Subpart D and La. R.S. 46:460.71, so that costs for services otherwise payable by the Contractor are cost avoided or recovered from a liable third party. The two methods used are cost avoidance and post-payment recovery. The Contractor shall use these methods in accordance with Federal and State laws, regulations, rules, policies, procedures, and manuals, and the State Plan.

4.13.1.4 Establishing TPL takes place when the Contractor receives confirmation that another party is, by law, contract, or agreement, legally responsible for the payment of a Claim for a health care item or service delivered to an Enrollee.

4.13.1.5 If the probable existence of TPL cannot be established, the Contractor shall Adjudicate the Claim. The Contractor shall then utilize post-payment recovery if TPL is later determined to exist.

4.13.1.6 The Contractor may utilize Subcontractors to comply with coordination of benefit (COB) efforts for services provided pursuant to this Contract. If the

Contractor intends to subcontract for COB TPL services or with a subrogation vendor to perform its accident/trauma-related recoveries, the Contractor shall notify LDH of the vendor and provide a copy of the contract to LDH or its designee during Readiness Reviews. The Contractor shall notify LDH of any subsequent changes to its vendor and provide a copy of the contract no later than thirty (30) Calendar Days prior to the effective date of the contract. Failure to comply may result in Monetary Penalties being assessed against the Contractor.

4.13.1.7 For the eligible Louisiana Medicaid Program population that is dually enrolled in Medicare, Medicaid-covered SBHS that are not covered by Medicare shall be paid by the Contractor as the primary payer. For dually eligible individuals, Medicare "crossover" Claims (Claims for services that are covered by Medicare as the primary payer) are excluded from coverage under the Capitation Payments. These services shall be administered separately by the FI from the services covered under the Capitation Payments effective under this Contract. In the event that a dually eligible Enrollee's Medicare benefits have been exhausted as of the date of service on which a Medicare covered behavioral health service was provided, Louisiana Medicaid Program shall be considered primary. Claims for those services shall no longer be considered "crossover" Claims, and the Contractor shall be responsible for payment.

4.13.1.8 The Contractor shall update its system with TPL records sent daily from LDH (or its designee) within one (1) Business Day of receipt. The Contractor shall reconcile its system with TPL reconciliation files sent weekly from LDH within one (1) Business Day of receipt. If an Enrollee is unable to access services or treatment until an update is made, the Contractor shall verify and update its system within four (4) Business Hours of receipt of an update request. This includes updates on coverage, including removal of coverage that existed prior to the Enrollee's linkage to the Contractor that impacts current provider adjudication or Enrollee service access. Such updates shall be submitted to LDH and/or its designee in the manner specified in the **MCO Manual**.

4.13.1.9 The Contractor shall review response files sent daily from LDH (or its designee) and rejected records shall be corrected and completed within five (5) Business Days. The Contractor shall ensure its records reconcile to the TPL reconciliation files received weekly from LDH or its designee. Failure to comply may result in Monetary Penalties in accordance with Attachment G, *Table of Monetary Penalties*.

4.13.1.10 TPL Data Exchange

4.13.1.10.1 The Contractor shall:

4.13.1.10.1.1 Receive, process, and update all records included in TPL files sent by LDH or its designee.

4.13.1.10.1.2 Update its TPL databases within one (1) Business Day of receipt of said files.

4.13.1.10.1.3 Transmit to LDH or its designee, in the formats and methods specified by LDH, TPL files the Contractor or its Subcontractor discovers that have not otherwise been provided by LDH or its designee.

4.13.2 Cost Avoidance and Pay and Chase

4.13.2.1 The Contractor shall cost-avoid a Claim if it establishes the probable existence of a liable third party other health insurance at the time the Claim is filed, except for the "pay and chase" Claims identified in the **MCO Manual**.

4.13.2.2 The Contractor shall "pay and chase" the full amount allowed under its payment schedule for the Claim and then seek reimbursement from the TPL insurer. The Contractor shall, within sixty (60) Calendar Days after the end of the calendar month in which the payment was made (or within sixty (60) Calendar Days after the end of the calendar month the Contractor learns of the existence of a liable third party), pursue recovery from said third party for any legal liability.

4.13.2.3 The Contractor shall "wait and see" on Claims for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the State Title IV-D agency. "Wait and see" is defined as payment of a Claim only after documentation is submitted to the Contractor demonstrating that one hundred (100) Calendar Days have elapsed since the provider billed the responsible third party and the provider has not received payment for such services.

4.14 Post-Payment Recoveries

4.14.1 Post-payment recovery is necessary in cases where the Contractor has not established the probable existence of TPL at the time services were rendered or paid for. The Contractor shall adhere to the following requirements for post-payment recovery:

4.14.1.1 Initiate recovery of reimbursement within sixty (60) Calendar Days after the end of the calendar month in which it learns of the existence of the liable third party.

4.14.1.2 Not perform post-payment recovery for TPL from providers for Claims with dates of service (DOS) older than ten (10) months, except when the primary carrier is traditional Medicare, Tricare, or Champus.

4.14.1.3 If the liable third party is traditional Medicare, Tricare or Champus, and more than ten (10) months have passed since the DOS, the Contractor shall recover from the provider.

4.14.1.4 Allow providers sixty (60) Calendar Days from the date stamp of the recovery letter to refute the recovery with a one-time thirty (30) Calendar Day extension at the provider's request.

4.14.1.5 Refer pay and chase Claims directly to the liable third parties.

4.14.1.6 Refer POS pharmacy Claims directly to the carrier.

4.14.1.7 The Contractor shall initiate an automatic recoupment at the expiration of the sixty (60) Calendar Day time period if an extension request is not received from the provider and at the expiration of the ninety (90) Calendar Day time period if an extension is requested by the provider if the provider has not remitted the payment to the Contractor

4.14.1.8 The Contractor shall void Encounters for Claims for which the full Louisiana Medicaid Program paid amount is being recouped. For recoupments for which the full Louisiana Medicaid Program paid amount is not being recouped, the Contractor shall submit adjusted Encounters for the Claims.

4.14.1.9 The Contractor shall identify the existence of potential TPL to pay for MCO Covered Services through the use of trauma code edits in accordance with 42 CFR §433.138(e).

4.14.1.10 The Contractor shall be required to seek reimbursement in accident/trauma related cases when Claims in the aggregate equal or exceed five hundred dollars ($500.00) as required by the State Plan and Federal Medicaid guidelines and may seek reimbursement when Claims in the aggregate are less than five hundred dollars ($500.00). Failure to seek reimbursement may result in Monetary Penalties as specified in Attachment G, *Table of Monetary Penalties*.

4.14.1.11 The Contractor shall notify LDH when subpoenas duces tecum are received and report the resulting recoveries to LDH.

4.14.1.12 The amount of any recoveries collected by the Contractor outside of the Claims processing system shall be treated by the Contractor as offsets to medical expenses for the purposes of reporting.

4.14.1.13 Prior to accepting a TPL settlement on accident/trauma-related Claims equal to or greater than twenty-five thousand dollars ($25,000.00), the Contractor shall obtain approval from LDH in writing.

4.14.1.14 Upon receipt of a subpoena duces tecum, the Contractor shall produce documents responsive to said subpoena by the date of return indicated therein (or shall contact the party who caused issuance of the subpoena, in order to request additional time to respond) if the production is authorized under La. R.S. 13:3715.1. Upon receipt of a request for records not sent via subpoena, the Contractor shall release PHI or a response

explaining why PHI cannot be released to the individual or entity making the request, within fifteen (15) Calendar Days of receipt of the request and a written authorization, as set forth in La. R.S. 40:1165.1(A)(2)(c). The Contractor is solely responsible for any sanctions and costs imposed by a court of competent jurisdiction for failure to comply with the requirements of La. R.S. 40:1165.1(A)(2)(c) or for failure to respond Timely to a subpoena duces tecum. Additionally, LDH may impose sanctions against the Contractor for failure to properly or Timely respond to requests for PHI.

4.14.1.15 All records requests received by the Contractor shall be investigated by the Contractor (or its vendor) for possible TPL recoveries, resulting in issuance of a lien statement (or notice of lack thereof) to the requesting party, as provided for in La. R.S. 46:446.

4.14.1.16 When the Contractor has actual knowledge that an insurer or other risk bearing entity of an Enrollee has filed for bankruptcy and the provider files a Claim for reimbursement with the Contractor with dates of service prior to the date the insurer or other risk bearing entity filed bankruptcy, the Contractor shall reimburse the provider with the Louisiana Medicaid Program as the primary insurer only if the Enrollee was enrolled with the Contractor at the time the service was provided and the provider has not been paid. The Contractor shall seek reimbursement as a creditor in the bankruptcy proceeding or from a liable third party. If the provider files a Claim for reimbursement with the Contractor with dates of service after the date the insurer or other risk bearing entity filed for Chapter 11 bankruptcy, the insurer or other risk bearing entity shall continue to be the primary insurer. If the provider files a Claim for reimbursement with the Contractor with dates of service after the date the insurer or other risk bearing entity filed for Chapter 7 bankruptcy, the Louisiana Medicaid Program shall be the primary insurer.

4.14.1.17 The Contractor shall maintain a system to monitor cases where the Louisiana Patient's Compensation Fund (PCF) has assumed liability for future medical payments for Medicaid recipients. The Contractor shall bill the PCF on at least an annual basis for future medical payments related to medical malpractice lawsuits, as established by either a judgment or a settlement Agreement, pursuant to La R.S. 40:1231.3.

4.14.2 Distribution of TPL Recoveries

4.14.2.1 The Contractor may retain up to one hundred (100%) of its TPL recoveries if all of the following conditions exist:

4.14.2.1.1 Total TPL recoveries received do not exceed the total amount of the Contractor's financial liability for the Enrollee.

4.14.2.1.2 There are no payments made by LDH related to FFS, reinsurance, or administrative costs (e.g., lien filing) for the Enrollee.

4.14.2.1.3 Such recovery is not prohibited by State or Federal law.

4.14.2.1.4 LDH shall utilize the TPL recovery data in calculating future Capitation Rates.

4.14.3 TPL Reporting Requirements

4.14.3.1 The Contractor shall provide TPL information to LDH in a format and medium described in the **MCO Manual** and shall cooperate in any manner necessary, as requested by LDH, with LDH and/or its designee.

4.14.3.2 The Contractor shall include the TPL recoveries and Claims information in the Encounter Data submitted to LDH, including any retrospective findings via Encounter adjustments or voids.

4.14.3.3 Upon the request of LDH, the Contractor shall provide information not included in Encounter Data submissions that may be necessary for the administration of TPL activity. The information shall be provided within thirty (30) Calendar Days of LDH's request. Such information may include, but is not limited to, Enrollee Medical Records for the express purpose of a liable third party to determine liability for the services rendered.

4.14.3.4 Upon the request of LDH, the Contractor shall demonstrate that reasonable effort has been made to seek, collect, and/or report TPL and recoveries. LDH shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices. Failure to seek reimbursement/recovery may result in Monetary Penalties as set forth in Attachment G, *Table of Monetary Penalties*.

4.14.3.5 The Contractor shall submit an annual report of all health insurance collections.

4.14.4 LDH Right to Conduct Identification and Pursuit of TPL

4.14.4.1 LDH may invoke its right to pursue TPL recoveries if the Contractor fails to recover reimbursement from the liable third party to the limit of legal liability within three hundred sixty-five (365) Calendar Days from date(s) of service of the Claim(s).

4.14.4.2 If LDH determines that the Contractor is not actively engaged in cost avoidance activities, the Contractor may be subject to Monetary Penalties as set forth in Attachment G, *Table of Monetary Penalties*.

4.15 Coordination of Benefits

4.15.1 Other Coverage Information

The Contractor shall provide TPL information it or its Subcontractor discovers for each Enrollee that is not included in the reconciliation files received weekly from the FI. The Contractor shall submit a TPL file sent daily reporting verified additions and updates of TPL information in a format and medium specified by LDH in the **MCO Manual**. The Contractor shall review response files sent daily from the FI and correct and resubmit rejected records until the record is correctly reported on TPL reconciliation files received weekly from the FI.

4.15.2 Reporting and Tracking

The Contractor's system shall identify and track potential TPL recoveries. The system shall produce reports indicating open receivables, closed receivables, amounts collected, amounts written off, and amounts avoided. These reports shall be made available to LDH upon request.

4.16 Financial Disclosures for Pharmacy Services

The Contractor shall disclose all financial terms and arrangements for remuneration of any kind that apply between the Contractor or the Contractor's PBM and any prescription drug wholesaler, manufacturer or labeler, including, without limitation, formulary management, educational support, Claims processing, pharmacy network fees, drug product sales or pricing agreements, data sales fees, and any other fees. The *Claims Management* section of this Contract provides that LDH or State auditors may audit such information at any time. LDH agrees to maintain the confidentiality of information disclosed by the Contractor pursuant to the Contract, to the extent that such information is confidential under State or Federal law.

4.17 Bond Requirements

4.17.1 Performance Bond

4.17.1.1 The Contractor shall establish and maintain a performance bond for the entire term of the Contract and continue to maintain the bond for at least fifteen (15) months following the termination date of this Contract or as long as the Contractor has Contract-related outstanding liabilities of at least fifty thousand dollars ($50,000.00), whichever is later, to guarantee: (1) payment of the Contractor's obligations to LDH and (2) performance by the Contractor of its obligations under this Contract (42 CFR §438.116).

4.17.1.2 The bond shall be obtained from an agent appearing on the United States Department of Treasury's list of approved sureties. The bond shall be made payable to the State of Louisiana. The Contract and dates of performance shall be specified in the bond.

4.17.1.3 The initial amount of the bond shall be equal to fifty million dollars ($50,000,000). The initial bond shall be submitted to LDH within ten (10) Calendar Days of Contract approval in writing by the Office of State Procurement.

4.17.1.4 The bond amount shall be reevaluated and adjusted following the Enrollment process, which includes the period during which Enrollees can change MCOs without cause. The adjusted amount shall be equal to fifty percent (50%) of the total Capitation Payment, exclusive of maternity Kick Payments, paid to the Contractor for the month following the end of the process. The adjusted bond shall be submitted to LDH within sixty (60) Calendar Days of notification to the Contractor of the adjusted amount.

4.17.1.5 All bonds newly submitted to LDH shall be original and have the raised embossed seal on the bond and on the Power of Attorney page. Continuation certificates may be submitted for renewed bonds. The Contractor shall retain a photocopy of the bond.

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

4.17.2 Fidelity Bond

4.17.2.1 The Contractor shall secure and maintain, during the term of the Contract, a blanket fidelity bond on all personnel in its employment.

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

Deleted: <#>Reimbursement for COVID-19 Vaccine Administration¶

<#>LDH will pay the Contractor, on a quarterly, non-risk basis, for the costs of COVID-19 vaccine administration to Contractor Enrollees in accordance with the Louisiana Medicaid COVID-19 Vaccine and Treatment Fee Schedule. This payment shall be separate from the monthly Capitation Payments and be based upon Encounter Data provided by the Contractor to LDH that have been accepted and have cleared all systems edits in the MMIS. This non-risk arrangement is subject to Federal requirements for payments under non-risk managed care contracts at 42 CFR § 447.362. ¶

<#>The Contractor shall submit all COVID-19 vaccine administration Encounters in accordance with the terms and conditions of this Contract. ¶

<#>The Contractor shall report expenditures for COVID-19 vaccine administration on a date of service basis.¶

<#>The Contractor shall pay COVID-19 vaccine administration Claims when performed and coded appropriately and according to the FFS fee schedule.¶

<#>Reimbursement for COVID-19 Vaccine Incentive Distribution¶

<#>LDH will pay the Contractor, on a monthly, non-risk basis, for the costs of COVID-19 vaccine incentive distribution to its Enrollees in accordance with the Louisiana Medicaid COVID-19 "Shot Per 100,000" COVID vaccine administration member incentive program. The Enrollee incentive amount paid shall be determined by LDH. The Contractor is entitled to a nine percent (9%) administration fee in addition to the amount of the incentive distributed through the "Shot Per 100,000" program. All payments associated with this program shall be paid on an administrative cost basis, separately from the monthly Capitation Payments. The Contractor will identify eligible Enrollees by leveraging LDH's existing data extraction processes and weekly COVID vaccine administration reports and by utilizing the Contractor's internal resources. The Contractor will use various data sources and internal databases to confirm Enrollee eligibility for the incentive. ¶

<#>The Contractor shall submit all data related to the COVID-19 vaccine incentive in accordance with the terms and conditions of this Contract and the reporting template developed for the "Shot Per 100,000" program.¶

<#>The Contractor shall report expenditures for COVID-19 vaccine incentives on a date of service basis.¶

<#>The Contractor shall distribute the COVID-19 vaccine incentive to Enrollees within five (5) Business Days of the Contractor validating the Enrollee's eligibility to receive the COVID-19 vaccine incentive.

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PART 5: TURNOVER REQUIREMENTS

5.1 General Turnover Requirements

Upon termination of the Contract, the Contractor shall:

5.1.1 Comply with all terms and conditions stipulated in the Contract, including but not limited to:

5.1.1.1 Continuation of MCO Covered Services to Enrollees until the effective date of termination; and

5.1.1.2 Compliance with all requirements that survive termination of the Contract (e.g., provider reimbursement, Encounter submissions, report submissions, record retention requirements, and other requirements with specific dates or time periods that extend beyond the effective date of termination) until the applicable date or at the end of the applicable time period specified in the Contract and the **MCO Manual**;

5.1.2 Promptly supply all information necessary for the reimbursement of any outstanding Claims;

5.1.3 Provide all reasonably necessary assistance to LDH in transitioning Enrollees out of the Contractor's plan upon termination of the Contract or to the extent specified in the notice of termination. Such assistance shall include, but be not limited to, forwarding medical and other records; facilitation and scheduling of medically necessary appointments for care and services; and identification of Enrollees with SHCN including those that are chronically ill, high risk, hospitalized or pregnant; and

5.1.4 Identify and maintain sufficient key personnel and support staff based in Louisiana to support all required Contract functions while any outstanding obligations under the Contract remain. The Contractor's transition team shall assist with Enrollee transitions to a new MCO and ensure the sharing of documentation such as active Prior Authorizations, current assessments and POCs, and other necessary information to support continuity of care, particularly for Enrollees with SHCN.

5.2 Turnover Plan

5.2.1 Upon written notification of termination of the Contract by either party, the Contractor shall submit a Turnover Plan within thirty (30) Calendar Days from the date of notification, unless other appropriate timeframes have been mutually agreed upon by both parties. If the Contract is not terminated by written notification, the Contractor shall submit a Turnover Plan six (6) months prior to the end of the Contract period, including any extensions to such period.

5.2.2 The Turnover Plan shall:

5.2.2.1 Be approved by LDH;

5.2.2.2 Detail the approach to ensure an efficient turnover that complies with all Contract requirements while minimizing disruption to Enrollees and

providers. At a minimum, the Turnover Plan shall specifically address the following:

5.2.2.2.1 Staffing plan and retention strategies;

5.2.2.2.2 Continuity of care;

5.2.2.2.3 Enrollee support and communication strategies;

5.2.2.2.4 Provider network and access to care standards;

5.2.2.2.5 Provider support and communication strategies;

5.2.2.2.6 Claims management, including provider payments and recoupments;

5.2.2.2.7 Reporting of deliverables due after contract termination; and

5.2.2.2.8 Monitoring and quality assurance processes;

5.2.2.3 Include a detailed work plan, in Excel format, that includes the proposed schedule, activities, resources, and dependencies associated with the turnover tasks, including tasks that extend beyond termination of the Contract;

5.2.2.4 Address the turnover of records and information maintained by the Contractor to either LDH or a third party designated by LDH;

5.2.2.5 Describe the Contractor's approach for the transfer of all records, data, and operational support information, as applicable, to either LDH or a third party designated by LDH; Include an itemization of all records, data, and operational support information (in broad categories) that will be transferred and the schedule for completion. The proposed transfer schedule should be phased and align around the effective date of termination (e.g., sixty (60) Calendar Days prior, thirty (30) Calendar Days prior, day of termination, thirty (30) Calendar Days after, etc.; and

5.2.2.6 Include copies of all relevant Enrollee and MCO Covered Services data, documentation, and other pertinent information necessary, as determined by LDH, for LDH or a subsequent MCO to assume the operational activities successfully. This includes, but is not limited to, correspondence, documentation of ongoing outstanding issues, and other operations support documentation.

5.3 Transfer of Data

5.3.1 The Contractor shall transfer all data regarding the provision of MCO Covered Services to LDH or a third party, at the sole discretion of LDH and as directed by LDH. All transferred data must be transferred in compliance with HIPAA.

5.3.2 All required transfers of data and information specified in this Contract shall be made electronically, unless otherwise directed by LDH, and according to the format and schedule approved by LDH.

5.3.3 All data received shall be verified by LDH or the subsequent MCO. If LDH determines that not all of the data regarding the provision of MCO Covered Services was transferred to LDH or the subsequent MCO, as required, or the data was not transferred in a HIPAA compliant manner, LDH reserves the right to hire an independent contractor to assist LDH in obtaining and transferring all the required data and to ensure that all the data was transferred in a HIPAA compliant manner. The Contractor shall be responsible for payment of all reasonable costs incurred by LDH for any such services provided by an independent contractor.

5.4 Post-Turnover Services

5.4.1 Thirty (30) Calendar Days following turnover of operations, the Contractor shall provide LDH with a Turnover Results report documenting the completion and results of each step of the Turnover Plan. Turnover shall not be considered complete until this document has been approved by LDH.

5.4.2 If the Contractor does not provide the required data and reference tables, documentation, and/or other pertinent information necessary for LDH or the subsequent MCO to assume the operational activities successfully, the Contractor agrees to reimburse LDH for all reasonable costs, including, but not limited to, transportation, lodging, and subsistence for all State and Federal representatives, or their agents, to carry out their inspection, audit, review, analysis, reproduction and transfer functions at the location(s) of such records.

5.4.3 The Contractor shall also pay any and all additional costs incurred by LDH that are the result of the Contractor's failure to provide the required records, data, and/or documentation within the time frames agreed to in the Turnover Plan. LDH may, at its sole discretion, deduct from the withhold of the final payment to satisfy the additional costs incurred.

5.4.4 The Contractor shall maintain all data and records related to Enrollees and providers for ten (10) years following termination of the Contract or until the resolution of all litigation, claims, financial management review or audit pertaining to the Contract, whichever is longer. Under no circumstances shall the Contractor or any of its Material Subcontractors destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

5.4.5 The Contractor agrees to repay any valid, undisputed audit exceptions taken by LDH in any audit of the Contract. LDH may, at its sole discretion, deduct from the withhold of the final payment for reimbursement of any amounts due related to the audit exception.

PART 6: TERMS AND CONDITIONS

6.1 General Terms

6.1.1 The Operational Start Date is anticipated to be January 1, 2023. LDH reserves the right to revise the anticipated Operational Start Date and shall provide the Contractor sixty (60) Calendar Days' prior notice of such change. The Contractor shall successfully complete a Readiness Review as specified in the *Contract Transition and Readiness* section of this Contract prior to the Operational Start Date.

6.1.2 The term of the Contract shall be thirty-six (36) months from the Operational Start Date unless terminated prior to that date in accordance with State or Federal law or terms of the Contract. With all proper approvals and concurrence of the Contractor, LDH may also exercise an option to extend the Contract for up to twenty-four (24) additional months at the same rates, terms, and conditions of the initial term, inclusive of any and all amendments. Prior to the extension of the Contract beyond the initial thirty-six (36) month term, approval by the Joint Legislative Committee on the Budget (JLCB) and/or other approval required by law shall be obtained. Written evidence of JLCB approval shall be submitted, along with the contract amendment to the Office of State Procurement (OSP) to extend contract terms beyond the initial thirty-six (36) month term. The total term of the Contract, with extensions, shall not exceed sixty (60) months. The continuation of the Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract.

6.1.3 The Contract shall not be valid, nor shall LDH be bound by the Contract, until it has first been executed by the head of the using agency, or his designee, and the Contractor and has been approved in writing by CMS and the director of OSP.

6.1.4 The Contractor shall comply, to the satisfaction of LDH, with: (1) all requirements set forth in this Contract; (2) all provisions of State and Federal laws, rules, regulations, policies, and procedures, the State Plan, and Waivers applicable to the Managed Care Program; and (3) the **MCO Manual**.

6.1.5 The Contractor shall comply with all settlement agreements, orders, and/or judgements rendered by a court of competent jurisdiction, including, but not limited to, those that arise from A.J. v. LDH (Case 3:19-CV-00324), Chisholm v. Phillips (Case 2:97-cv-03274), and United States v. State of Louisiana (DOJ Agreement, Case-3:18-cv-00608), and subsequent implementation plans in accordance with the Contract, the **MCO Manual**, and as directed by LDH. LDH reserves the right to assess Monetary Penalties for failure to meet this requirement.

6.1.6 LDH reserves the right to provide written clarification for non-material changes of Contract requirements whenever deemed necessary, at any point in the Contract period, to ensure the proper and efficient administration of the Managed Care Program. Such clarifications shall be implemented by the Contractor and shall not require an amendment to the Contract.

6.1.7 LDH, at its discretion, may issue correspondence to inform the Contractor of changes in Louisiana Medicaid Program policies and procedures which may affect the Contract. Unless otherwise specified in the Louisiana Medicaid Program correspondence, the Contractor shall be given sixty (60) Calendar Days to implement such changes.

6.2 Amendments

6.2.1 No amendment shall be valid until executed by all parties and approved in writing by OSP in accordance with La. R.S. 39:1595.1. Any amendment to the Contract may require approval of CMS prior to the amendment implementation.

6.2.2 LDH, in its sole discretion, may pursue an amendment to the Contract at any time. Prior to submission of the amendment for the requisite approval(s), LDH may solicit feedback from the Contractor on the proposed amendment language. However, LDH retains final decision-making authority on the language that will ultimately be submitted to CMS and OSP for review and approval.

6.2.3 Unless otherwise specified by LDH, the Contractor shall implement all provisions of an amendment no later than sixty (60) Calendar Days from the date the Contractor receives the fully executed amendment.

6.2.4 Should the Contractor refuse to accept an amendment, it may submit a written request to LDH to terminate the Contract with an effective date of at least sixty (60) Calendar Days from the date of LDH's receipt of the written request. LDH shall have sole discretion to approve or deny the request for termination and to impose such conditions on the granting of an approval as it may deem appropriate.

6.2.5 LDH may terminate the Contract if the Contractor fails to execute an amendment within ten (10) Calendar Days of delivery.

6.2.6 If the Contract is terminated in accordance with 6.2.4 or 6.2.5, at a minimum, the requirements set forth in Part 5: Turnover Requirements and the *Bond Requirements* section shall apply.

6.3 Rate Adjustments

6.3.1 The Capitation Rates identified in this Contract shall be in effect during the periods identified in the rate certifications posted on LDH's website. Capitation Rates may be adjusted during the term of the Contract based on LDH and actuarial analysis, subject to CMS review and approval.

6.3.2 Adjustments to the Capitation Rate(s) shall be implemented through a written amendment to the Contract.

6.4 References to Laws, Rules, or Regulations

All references in this Contract to any law, rule, or regulation shall be deemed to refer to the law, rule, or regulation in effect at the time of the issuance of this Contract or as they may be hereafter amended. Throughout the term of the Contract, including any extension(s), the Contractor shall comply with the laws, rules, and regulations in effect at that time.

6.5 Applicable Laws and Regulations

The Contractor agrees to comply with all applicable Federal and State laws, regulations, and rules, and shall ensure compliance by Subcontractors and Network Providers, including, but not limited to:

6.5.1 Constitutional provisions regarding due process and equal protection.

6.5.2 Code of Federal Regulations CFR, Title 42, Chapter IV, Subchapter C (Medical Assistance Programs).

6.5.3 Provisions relating to managed care in 42 U.S.C. §1396u-2.

6.5.4 All applicable standards, orders, or regulations issued pursuant to the Clean Air Act, as amended (42 U.S.C. §7401, et seq.), regulations issued pursuant thereto; the Clean Water Act, as amended (33 U.S.C. §1251, et seq.), and regulations issued pursuant thereto; and the Pro-Children Act of 1994 (20 U.S.C. §6081, et seq.) and regulations issued pursuant thereto.

6.5.5 The Balanced Budget Act of 1997, as amended (P.L. 105-33), and regulations issued pursuant thereto; and the Balanced Budget Refinement Act of 1999, as amended (P.L. 106-113), and regulations issued pursuant thereto.

6.5.6 Section 1128 of the Social Security Act (42 U.S.C. §1320a-7) and regulations issued pursuant thereto, relating to exclusion of certain individuals and entities from participation in Medicare and the Louisiana Medicaid Program.

6.5.7 Section 1156 of the Social Security Act (42 U.S.C. §1320c-5) and regulations issued pursuant thereto.

6.5.8 The Drug Free Workplace Act of 1988, as amended (41 U.S.C. §8101, et seq.), and regulations issued pursuant thereto.

6.5.9 The Byrd Anti-Lobbying Amendment (31 U.S.C. §1352) and regulations issued pursuant thereto, which provide that the Contractor and its Subcontractor(s) shall file the required certification. Each tier certifies to the tier above, that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any 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 must also disclose any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier-to-tier up to the non-Federal award.

6.5.10 The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) and regulations pursuant thereto, which require coverage for mental health and substance use disorders to be no more restrictive than the coverage that generally is available for medical/surgical conditions.

6.6 Civil Rights Compliance

The Contractor agrees to abide by the following requirements, as applicable:

6.6.1 Section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. §18116) and regulations issued pursuant thereto; Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d, et seq.), and regulations issued pursuant thereto; Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000e, et seq.), and regulations issued pursuant thereto; Title IX of the Education

Amendments of 1972 (20 U.S.C. §1681, et seq.) and regulations issued pursuant thereto; the Age Discrimination Act of 1975, as amended (42 U.S.C. §6101, et seq.), and regulations issued pursuant thereto; Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), and regulations issued pursuant thereto; Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. §794d) and regulations issued pursuant thereto; the Americans with Disabilities Act of 1990, as amended (42 U.S.C. §12101, et seq.), and regulations issued pursuant thereto; the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. §4212) and regulations issued pursuant thereto; the Fair Housing Act of 1968 (42 U.S.C. §3601, et seq.) and regulations issued pursuant thereto; and Federal Executive Order 11246.

6.6.2 The Contractor agrees not to discriminate in its employment practices, and will render services under this Contract without regard to race, color, religion, sex, sexual orientation, national origin, , veteran status, political affiliation, disability, or age in any matter relating to employment.

6.6.3 The Contractor agrees that no person, on the grounds of these factors, shall be excluded from participation in, or be denied benefits of the Contractor's program, or be otherwise subjected to discrimination in the performance of this Contract. The Contractor shall not use any policy or practice, including its employment practices, that has the effect of discriminating on these factors. Any act of discrimination committed by the Contractor, or failure to comply with these statutory obligations, when applicable, as determined by LDH in its sole discretion, shall be grounds for termination of this Contract.

6.6.4 In all hiring or employment made possible by or resulting from this Contract, the Contractor shall take affirmative action to ensure that applicants are employed and that employees are treated during employment in accordance with all applicable State and Federal laws regarding employment of personnel.

6.6.5 This requirement shall apply to, but not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training including apprenticeship. The Contractor further agrees to give public notice in conspicuous places available to employees and applicants for employment setting forth the provisions of this Section. All solicitations or advertisements for employees shall state that all qualified applicants will receive consideration for employment without regard to disability, age, race, color, religion, sex, national origin, or sexual orientation. All inquiries made to the Contractor concerning employment shall be answered without regard to handicap, age, race, color, religion, sex, national origin veteran status, political affiliation, or sexual orientation. All responses to inquiries made to the Contractor concerning employment made possible as a result of this Contract shall conform to Federal, State, and local regulations.

6.6.6 The Contractor shall post notices of non-discrimination in conspicuous places, available to all employees and applicants. This provision shall be included in all Network Provider Agreements and subcontracts.

6.7 Payment of Premium Taxes

The Contractor shall be responsible for payment of all premium taxes assessed on the Capitation Payments to the Louisiana Department of Insurance according to the schedule established in La. R.S. 22:845.

6.8 Confidentiality of Information

6.8.1 All financial, statistical, personal, technical and other data and information relating to the State's operation which are designated confidential by the State and made available to the Contractor in order to carry out this Contract, or which become available to the Contractor in carrying out this Contract, shall be protected by the Contractor from unauthorized use and disclosure through the observance of the same or more effective requirements as are applicable to the State. The identification of all such confidential data and information as well as the State's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by the State in writing to the Contractor. If the methods and procedures employed by the Contractor for the protection of the Contractor's data and information are deemed by the State to be adequate for the protection of the State's confidential information, such methods and procedures may be used, with the written consent of the State, to carry out the intent of this paragraph. The Contractor shall not be required under the provisions of this paragraph to keep confidential any data or information which is or becomes publicly available, is independently developed by the Contractor outside the scope of the Contract, or is lawfully obtained free of restriction from a third party having the right to furnish such confidential data or information.

6.8.2 Under no circumstance shall the Contractor discuss and/or release information to the media concerning this Contract without prior express written approval of LDH.

6.9 Conflict of Interest

6.9.1 The Contractor acknowledges that Chapter 15 of Title 42 of the Louisiana Revised Statutes (La. R.S. 42:1101 et seq., Code of Governmental Ethics) applies to the Contractor in the performance of services called for in this Contract. The Contractor agrees to immediately notify the State if potential violations of the Code of Governmental Ethics arise at any time during the term of this Contract.

6.9.2 The Contractor shall comply with the prohibitions set forth in 42 U.S.C. §1396a(a)(4)(C).

6.9.3 Neither the Contractor nor any Material Subcontractor shall, for the duration of the Contract, have any interest that will conflict or appears to conflict, as determined by LDH, with the performance of services under the Contract, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, LDH requires that neither the Contractor nor any Material Subcontractor have any financial, legal, contractual, or other business interest in any entity performing Enrollment functions for the Managed Care Program.

6.10 Warranty of Removal of Conflict of Interest

The Contractor warrants that it, its officers, and its employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services hereunder. The Contractor shall inquire of its officers and employees concerning such conflicts at least quarterly, and shall inform LDH of any potential or actual conflict(s) within one (1) Business Day of discovery. The Contractor warrants that it shall remove any conflict of interest prior to signing the Contract and during the term of the Contract.

6.11 Contract Controversies

Any claim or controversy arising out of the Contract shall be resolved by the provisions of La. R.S. 39:1672.2-1672.4.

6.12 Contract Language Interpretation

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

6.13 Interpretation Dispute Resolution Procedure

6.13.1 The Contractor may request that LDH provide a determination with respect to the application of any provision of this Contract required for proper performance of the services under this Contract. Any such request must be submitted in writing to the Medicaid Deputy Director for Program Operations and Compliance.

6.13.2 If the Contractor does not agree with the interpretation provided by the Medicaid Deputy Director, the Contractor may request reconsideration. The request for reconsideration must be submitted in writing to the Medicaid Executive Director and include an explanation of about the reason for the disagreement. The deadline for requesting reconsideration is twenty-one (21) Calendar Days after receipt of the response from the Medicaid Deputy Director.

6.13.3 The option to dispute an interpretation does not apply to language in the Contract that is based on Federal or State laws, regulations, policies, procedures, or manuals, the State Plan, or Waivers.

6.13.4 The Medicaid Executive Director will render his or her final decision based upon written submissions from the Contractor and the Medicaid Deputy Director for Program Operations and Compliance, unless, at the sole discretion of the Medicaid Executive Director, the Medicaid Executive Director allows oral presentations by the Contractor and the Medicaid Deputy Director or his/her designee. If such a presentation is allowed, the information presented shall be considered in rendering the decision.

6.13.5 The Medicaid Executive Director shall reduce his or her decision to writing and provide a copy to the Contractor. The written decision of the Medicaid Executive Director shall be the final decision of LDH.

6.13.6 Pending final determination of any dispute over a LDH decision, the Contractor shall proceed diligently with the performance of the Contract and in accordance with the direction of LDH.

6.14 Cooperation with Other Contractors

In the event that LDH has entered into, or enters into, agreements with other contractors for additional work related to the services rendered under this Contract, including, but not limited to, FI and Enrollment Broker services, the Contractor agrees to cooperate fully with such other

contractors. The Contractor shall not commit any act that will interfere with the performance of work by any other LDH contractor.

6.15 Copyrights

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

6.16 Corporation Requirements

If the Contractor is a corporation, the following requirement shall be met prior to execution of the Contract:

6.16.1 If the Contractor is a for profit corporation whose stock is not publicly traded, the Contractor must file a Disclosure of Ownership form with the Louisiana Secretary of State.

6.16.2 If the Contractor is a corporation not incorporated under the laws of the State of Louisiana, the Contractor shall obtain a Certificate of Authority from the Louisiana Secretary of State, in accordance with La. R.S. 12:301, *et seq.*

6.16.3 The Contractor's legal counsel shall provide written assurance to LDH that the Contractor is not prohibited by its articles of incorporation, bylaws, or the laws under which it is incorporated from performing the services required under the Contract.

6.16.4 Secure and attach to the Contract a formal Board Resolution indicating the signatory to the Contract is a corporate representative and authorized to sign said Contract.

6.17 Debarment/Suspension/Exclusion

6.17.1 The Contractor agrees to comply with all applicable provisions of 2 CFR Part 376, pertaining to nonprocurement debarment and/or suspension, and 42 CFR §438.610, pertaining to prohibited affiliations.

6.17.2 The Contractor shall screen all directors, officers, partners, persons with beneficial ownership of five percent (5%) or more, Subcontractors, Network Providers, and persons with an employment, consulting, or other arrangement with the Contractor to determine whether they have been excluded from participation in Medicare, Medicaid, CHIP, and/or any other Federal health care programs.

6.17.3 The Contractor shall conduct such screenings monthly to capture exclusions and reinstatements that have occurred since the last search, and any exclusion information discovered should be immediately reported to LDH.

6.17.4 Any individual or entity that employs or subcontracts with an excluded provider cannot claim reimbursement from the Louisiana Medicaid Program for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Louisiana Medicaid Program 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 Beneficiary cannot claim reimbursement from the Louisiana Medicaid Program for that prescription. Civil Monetary Penalties may be imposed against Providers who employ or enter into Provider Agreements with excluded individuals or entities to provide items or services to Enrollees. See 42 U.S.C. §1320a-7 and §1320a-7a and 42 CFR §1003.140(a)(2).

6.18 Employee Education about False Claims Recovery

If annual payments to the Contractor equal five million dollars ($5,000,000) or more in accordance with 42 U.S.C. §1396a(a)(68) and regulations issued pursuant thereto, the Contractor must:

6.18.1 Establish written policies for all employees of the Contractor (including management), and of any Subcontractor or agent of the Contractor, that provide detailed information about the False Claims Act established under 31 U.S.C. §§3729 through 3733, administrative remedies for false claims and statements established under 31 U.S.C. Chapter 38, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting Fraud, Waste, and Abuse in Federal health care programs (as defined in 42 U.S.C. §1320a-7b(f)).

6.18.2 Include as part of such written policies, detailed provisions regarding the Contractor's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

6.18.3 Include in any employee handbook for the Contractor, a specific discussion of the laws described in 6.18.1, the rights of employees to be protected as whistleblowers, and the Contractor's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

6.19 Entire Contract and Order of Precedence

6.19.1 This Contract and any amendments thereof, including the RFP and any addenda issued thereto, the proposal submitted by the Contractor, and any attachments, appendices, and exhibits specifically incorporated therein by reference, constitute the entire agreement between the parties with respect to the subject matter.

6.19.2 This Contract shall, to the extent possible, be construed to give effect to all provisions contained therein. However, in the event of any inconsistency or conflict among the document elements of this Contract, such inconsistency or conflict shall be resolved by giving precedence to the following documents in the following order:

6.19.2.1 Attachment A, *Model Contract* and any amendments thereof.

6.19.2.2 The LDH Standard Contract Form – CF-1, exhibits, and other attachments incorporated therein, and amendments thereof.

6.19.2.3 The MCO Manual.

6.19.2.4 The RFP, attachments and exhibits incorporated therein, and addenda issued thereto.

6.19.2.5 The Proposal submitted by the Contractor in response to the RFP and appendices, attachments, and exhibits thereto or incorporated therein.

6.20 Governing Law and Venue

This Contract shall be governed by and interpreted in accordance with the laws of the State of Louisiana, except its conflict of laws provisions. Any administrative proceeding, action at law, suit in equity, or judicial proceeding for the enforcement of this Contract or any provision thereof shall be instituted only in the administrative tribunals and courts of the State of Louisiana. Specifically, any State court suit shall be filed in the 19th Judicial District Court for East Baton Rouge Parish as the exclusive venue for same, and any Federal suit shall be filed in the U.S. District Court for the Middle District of Louisiana as the exclusive venue for same. This Section shall not be construed as granting a right or cause of action to the Contractor in any of the aforementioned Courts.

6.21 Attorney Fees

In the event LDH should prevail in any legal action arising out of the performance or non-performance of the Contract, the Contractor shall pay, in addition to any penalties or damages awarded, all expenses of such action including, but not limited to, reasonable attorney fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

The Contractor is prohibited from expending funds received from LDH under this Contract to dispute, appeal, or take legal action arising out of the performance or non-performance of the Contract.

6.22 Confidentiality of Patient and Enrollee Records – HIPAA

The Contractor shall comply with HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (the HITECH Act) and the rules and regulations promulgated thereunder (45 CFR Parts 160, 162, and 164). The Contractor shall ensure compliance with all HIPAA requirements across all systems and services related to this Contract, including transaction, common identifier, and privacy and security standards, by the effective date of those rules and regulations. The Contractor shall protect the privacy and confidentiality of medical records and any and all other health and Enrollment information relating to Enrollees or Potential Enrollees, which is provided to or obtained by or through the Contractor's performance under this Contract, whether verbal, written, electronic file, or otherwise, as required by applicable provisions of 45 CFR Parts 160 and 164 and other State and Federal laws, or this Contract. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify particular individuals.

6.23 HIPAA Business Associate Provisions

As a "business associate" of LDH, as that term is defined in the HIPAA Privacy Rule, the Contractor shall comply with the HIPAA Business Associate provisions found in Section 43 of the LDH Standard Contract Form (CF-1).

6.24 Confidentiality of Patient and Enrollee Records – Substance Use Treatment Records

The Contractor shall comply with the requirements of 42 U.S.C. §290dd-2 and its implementing regulations, 42 CFR Part 2. The Contractor shall strictly maintain the confidentiality of patient records of drug, alcohol, and other drug treatment programs in addition to treatment and assessment for pathological or compulsive gambling.

The Contractor shall ensure that every Enrollee treated by a provider that is a covered Part 2 Program, as defined in 42 CFR §2.11, is offered the opportunity to sign a consent form for the disclosure of substance use treatment information to the Enrollee's PCP for the purpose of health care integration in accordance with 42 CFR Part 2, Subpart C.

The Contractor shall have the ability to track provider compliance with offering consent forms for Enrollees receiving substance use services from Part 2 Programs, including the number of Enrollees receiving substance use services by each provider and the number of consent forms offered and signed. The Contractor shall report this information to LDH upon request.

When substance use information is subject to the requirements of 42 CFR Part 2, any disclosure of that information without the written consent of the patient shall comply with 42 CFR Part 2 and shall be accompanied by a statement notifying the recipient of the prohibition against re-disclosure.

The Contractor shall develop policies and procedures which outline HIPAA requirements and 42 CFR Part 2 requirements for the purpose of health care integration. These policies and procedures shall outline instances in which 42 CFR Part 2 requirements override HIPAA requirements.

The Contractor shall educate contracted Network Providers on protocols for requesting and receiving patient records in accordance with 45 CFR Parts 160 and 164 and 42 CFR Part 2.

6.24.1 HIPAA Disclosure Process

6.24.1.1 The Contractor and its Subcontractors shall protect confidential information and documents in accordance with 42 U.S.C. §671(a)(8), 42 U.S.C. §5106a, 42 U.S.C. §290dd-2, 45 CFR §1355.21, 45 CFR §205.50, 45 CFR §1355.30, 42 CFR Part 2, La. R.S. 46:56, and 45 CFR Parts 160 and 164, as applicable. The Contractor shall disclose in writing any use or disclosure of PHI by the Contractor or any of its Subcontractors other than as permitted by the Contract within forty-eight (48) hours of becoming aware of the use or disclosure.

6.24.1.2 The Contractor is required to submit incident reports affecting Providers or Enrollees receiving services to LDH with a CAP and timelines for implementation of correction for approval by LDH within ten (10) Business Days of the Contractor's discovery of any HIPAA breaches, as defined at 45 CFR §164.402, that are committed by the Contractor or any of its Subcontractors. The incident report shall include, at a minimum:

6.24.1.2.1 Date of discovery.

6.24.1.2.2 Date or date range of violation/potential violation.

6.24.1.2.3 Cause of the incident including sequence and mechanisms.

6.24.1.2.4 Number of unauthorized individuals who viewed PHI.

6.24.1.2.5 Number of affected individuals whose PHI was compromised.

6.24.1.2.6 Steps taken to correct this incident to date, and planned steps to correct incident.

6.24.1.2.7 Steps taken to prevent reoccurrence from happening in the future.

6.24.1.2.8 Steps taken to mitigate any harmful effects caused by the unauthorized disclosure.

6.24.1.2.9 Any training or other corrective action targeted to the Contractor.

6.24.1.2.10 Plans for notification of CMS/HHS.

6.24.1.2.11 Notification plan to individuals.

6.24.1.2.12 A risk assessment which includes the following:

6.24.1.2.12.1 The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification.

6.24.1.2.12.2 The unauthorized person who used the PHI or to whom the disclosure was made.

6.24.1.2.12.3 Whether the PHI was actually acquired or viewed.

6.24.1.2.12.4 The extent to which the risk to the PHI has been mitigated.

6.25 Release of Records

The Contractor shall release Medical Records upon request by Enrollees or their Authorized Representatives, as may be directed by authorized personnel of LDH, appropriate agencies of the State of Louisiana, or Federal agencies. Release of Medical records shall be consistent with the provisions of confidentiality as set forth in this Contract. The ownership and procedure for release of Medical Records shall be controlled by the State and Federal law and regulations, including but not limited to, La. R.S. 40:1165.1, La. R.S. 13:3734, La. C. E. art. 510, and 45 CFR Parts 160 and 164, and subject to reasonable charges. The Contractor shall not charge LDH or its designee for any copies of Medical Records requested.

6.26 Security

6.26.1 Contractor's personnel shall comply with all security regulations in effect at the State's premises and externally for materials and property belonging to the State or to the project. Where special security precautions are warranted (e.g., correctional facilities), the State shall provide such procedures to the Contractor, accordingly.

6.26.2 The Contractor shall comply with the Office of Technology Services' (OTS) Information Security Policy at http://www.doa.la.gov/Pages/ots/InformationSecurity.aspx.

6.26.3 The Contractor is responsible for reporting to the State any known Data Breach or Security Event, as defined in the OTS Information Security Policy, no later than forty-eight (48) hours after confirmation of the event. The Contractor shall notify the Information Security Team ("IST") by calling Security Hotline at 1-844-692-8019 and emailing the security team at infosecteam@la.gov.

6.27 Safeguarding Information

The Contractor shall establish written safeguards that restrict the use and disclosure of information concerning Enrollees or Potential Enrollees to purposes directly connected with the performance of this Contract. The Contractor's written safeguards shall:

6.27.1 Be comparable to those imposed upon the LDH by 42 CFR Part 431, Subpart F, and La. R.S. 46:56;

6.27.2 State that the Contractor will identify and comply with any stricter State or Federal confidentiality standards which apply to specific types of information or information obtained from outside sources;

6.27.3 Require a written authorization from the Enrollee or Potential Enrollee before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR §164.508;

6.27.4 Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

6.27.5 Specify appropriate personnel actions to sanction violators.

6.28 Homeland Security Considerations

6.28.1 The Contractor shall perform all services under this Contract within the United States. The term "United States" includes the fifty (50) states, the District of Columbia, and U.S. territories. In addition, the Contractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

6.28.2 If the Contractor performs services, or uses services, in violation of the foregoing paragraph, the Contractor shall be in material breach of this Contract and shall be liable to LDH for any costs, fees, damages, claims, or expenses it may incur. LDH may impose any sanction, up to and including termination for cause, for violation of this section. Additionally, the Contractor shall be required to hold harmless and indemnify LDH pursuant to the indemnification provisions of this Contract.

6.28.3 The prohibitions in this Section shall also apply to any and all agents and Subcontractors of the Contractor to perform any services under this Contract.

6.29 Safety Precautions

LDH assumes no responsibility with respect to accidents, illnesses, or claims arising out of any activity performed under this Contract. The Contractor shall take necessary steps to insure or protect its Enrollees, itself, its personnel, Providers, and any Subcontractor. The Contractor agrees to comply, and ensure that all of its Subcontractors comply, with all applicable local, State, and Federal occupational and safety laws, rules, and regulations.

6.30 Licenses and Permits

6.30.1 The Contractor shall secure and maintain all licenses and permits, and pay inspection fees required to do the work in accordance with this Contract.

6.30.2 The Contractor shall secure and maintain an active license or certificate of authority issued by the Louisiana Department of Insurance to operate as a Medicaid risk bearing "prepaid entity" pursuant to La. R.S. 22:1016.

6.31 Solvency Requirement

The Contractor shall comply with all Louisiana Department of Insurance applicable standards. The Contractor shall meet solvency standards as specified in 42 CFR §438.116 and Title 22 of the Louisiana Revised Statutes.

6.32 Insurance Requirements

6.32.1 The Contractor shall purchase and maintain for the term of the Contract, insurance against claims for injuries to persons or damages to property that may arise from or in connection with the performance of the work hereunder by the Contractor, its agents, representatives, employees, Providers, or Subcontractors. The Contractor shall not commence work under this Contract until it has obtained, at its own cost and expense, all insurance required herein.

6.32.1.1 The Contractor shall not allow any Subcontractor to commence work on a subcontract until all insurance required for the Subcontractor has been obtained and approved.

6.32.1.2 Minimum Scope and Limits of Insurance for Workers' Compensation

6.32.1.2.1 Employers Liability is included with a minimum limit of one million dollars ($1,000,000) per accident/per disease/per employee. If work is to be performed over water and involves maritime exposure, applicable Longshore and Harbor Workers' Compensation Act (33 U.S.C. §901, et seq.), Merchant Marine Act of 1920 (46 U.S.C. §30104), or other maritime law coverage shall be included.

6.32.1.3 Commercial General Liability

6.32.1.3.1 Commercial General Liability insurance, including Personal and Advertising Injury Liability and Products and Completed Operations Liability coverage, shall have a minimum limit per occurrence of two million dollars ($2,000,000) and a minimum general annual aggregate of

four million dollars ($4,000,000). The Insurance Services Office (ISO) Commercial General Liability occurrence coverage form CG 00 01 (current form approved for use in Louisiana), or equivalent, shall be used in the policy. Claims-made form is unacceptable.

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

6.32.1.4 Professional Liability (Errors and Omissions)

6.32.1.4.1 Professional Liability (Error & Omissions) insurance, which covers the professional errors, acts, or omissions of the Contractor, shall have a minimum limit of three million dollars ($3,000,000) per claim. Claims-made coverage is acceptable. The date of the inception of the policy shall be no later than the first date of the anticipated work under this Contract. It shall provide coverage for the duration of this Contract and shall have an expiration date no earlier than thirty (30) Calendar Days after the anticipated termination date of the Contract. The policy shall provide an extended reporting period of not less than thirty-six (36) months, with full reinstatement of limits, from the expiration date of the policy, if the policy is not renewed.

6.32.1.5 Automobile Liability

6.32.1.5.1 Automobile Liability Insurance shall have a minimum combined single limit per accident of one million dollars ($1,000,000). ISO form number CA 00 01 (current form approved for use in Louisiana), or equivalent, shall be used in the policy. This insurance shall include third-party bodily injury and property damage liability for owned, hired, and non-owned automobiles.

6.32.2 Cyber Liability

6.32.2.1 Cyber liability insurance, including first-party costs, due to an electronic breach that compromises the State's confidential data shall have a minimum limit per occurrence of five million dollars ($5,000,000). Claims-made coverage is acceptable. The date of the inception of the policy shall be no later than the first date of the anticipated work under this Contract. It shall provide coverage for the duration of this Contract and shall have an expiration date no earlier than thirty (30) Calendar Days after the anticipated termination date of the Contract. The policy shall provide an extended reporting period of not less than thirty-six (36) months from the expiration date of the policy, if the policy is not renewed. The policy shall not be cancelled for any reason, except non-payment of premium.

6.32.3 Deductibles and Self-Insured Retentions

Any deductibles or self-insured retentions shall be declared to and accepted by LDH. The Contractor shall be responsible for all deductibles and self-insured retentions.

6.32.4 Other Insurance Provisions

6.32.4.1 Commercial General Liability, Automobile Liability, and Cyber Liability policies shall contain, or be endorsed to contain, the following provisions:

6.32.4.1.1 LDH, its officers, agents, employees, and volunteers shall be named as an additional insured as regards negligence by the Contractor. ISO Forms CG 20 10 (for ongoing work) AND CG 20 37 (for completed work) (current forms approved for use in Louisiana), or equivalents, shall be used when applicable. The coverage shall contain no special limitations on the scope of protection afforded to LDH.

6.32.4.1.2 The Contractor's insurance shall be primary with respect to LDH, its officers, agents, employees, and volunteers for any and all losses that occur under the Contract. Any insurance or self-insurance maintained by LDH shall be in excess and non-contributory of the Contractor's insurance.

6.32.4.2 Workers' Compensation and Employers Liability policies shall contain, or be endorsed to contain, the following provision:

6.32.4.2.1 To the fullest extent allowed by law, the insurer shall agree to waive all rights of subrogation against LDH, its officers, agents, employees, and volunteers for losses arising from work performed by the Contractor for LDH.

6.32.4.3 All policies shall contain, or be endorsed to contain, the following provisions:

6.32.4.3.1 All policies must be endorsed to require thirty (30) Calendar Days' written notice of cancellation to LDH. Ten (10) Calendar Days' written notice of cancellation is acceptable for non-payment of premium. Notifications shall comply with the standard cancellation provisions in the Contractor's policy. In addition, the Contractor is required to notify LDH of policy cancellations or reductions in limits.

6.32.4.3.2 The acceptance of the completed work, payment, failure of LDH to require proof of compliance, or LDH's acceptance of a non-compliant certificate of insurance shall not release the Contractor from the obligations of the insurance requirements or indemnification agreement.

6.32.4.3.3 The insurer issuing the policies shall have no recourse against LDH for payment of premiums or for assessments under any form of the policies.

6.32.4.3.4 Any failure of the Contractor to comply with reporting provisions of the policy shall not affect coverage provided to LDH, its officers, agents, employees, and volunteers.

6.32.5 Acceptability of Insurers

6.32.5.1 All required insurance shall be provided by a company or companies lawfully authorized to do business in the State of Louisiana. Insurance shall be placed with insurers with an A.M. Best's rating of A-:VI or higher.

This rating requirement may be waived for Workers' Compensation coverage only.

6.32.5.2 If, at any time, an insurer issuing any such policy does not meet the minimum A.M. Best rating, the Contractor shall obtain a policy with an insurer that meets the minimum A.M. Best rating and shall submit another certificate of insurance within thirty (30) Calendar Days of discovery or notification that the insurer does not meet the minimum rating.

6.32.6 Verification of Coverage

6.32.6.1 Contractor shall furnish LDH with certificates of insurance reflecting proof of required coverage. The certificates of insurance for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf. The certificates of insurance are to be received and approved by LDH before work commences and upon any renewal of the Contract or insurance policy renewal thereafter.

6.32.6.2 The Certificate Holder shall be listed as follows:

State of Louisiana
Louisiana Department of Health, Bureau of Health Services Financing, Its Officers, Agents, Employees, and Volunteers
628 4th Street, Baton Rouge, Louisiana 70802
Contract number, to be determined

6.32.6.3 In addition to the certificates of insurance, the Contractor shall submit the declarations page and the cancellation provision for each insurance policy. LDH reserves the right to request complete certified copies of all required insurance policies at any time.

6.32.6.4 Upon failure of the Contractor to furnish, deliver, and maintain required insurance, this Contract, at the election of LDH, may be terminated. Failure of the Contractor to purchase and/or maintain any required insurance shall not relieve the Contractor from any liability or indemnification under the Contract.

6.32.7 Subcontractors

Contractor shall include all Subcontractors as insureds under its policies OR shall be responsible for verifying and maintaining the certificates of insurance provided by each Subcontractor. 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 or in a reduced amount if approved by LDH at its sole discretion. Subcontractors shall be subject to all of the requirements stated herein. The Contractor shall furnish LDH with each Subcontractor's certificates of insurance upon request.

6.32.8 Additional Requirements for Transportation Broker

6.32.8.1 Commercial General Liability

If the Contractor elects to contract with a Transportation Broker, the Contractor shall require its Transportation Broker to maintain, during the life of the contract between the Contractor and the Transportation Broker, Commercial General Liability Insurance, with a minimum limit per occurrence of one million dollars ($1,000,000) and a minimum general aggregate of two million dollars ($2,000,000), to protect the Contractor, LDH, the Transportation Broker and any Subcontractor or provider during the performance of work covered by the Contract or the contract between the Contractor and the Transportation Broker from claims or damages for personal injury, including accidental death, as well as from claims for property damages, which may arise from operations under the Contract or the contract between the Contractor and the Transportation Broker, whether such operations be by the Contractor or by the Transportation Broker, Subcontractor, or provider, or by anyone directly or indirectly employed by them, or in such a manner as to impose liability to LDH. If the Contractor does not contract with a Transportation Broker, the Contractor shall maintain the insurance described in this section. The Contractor and Transportation Broker, if one is utilized, are prohibited from passing the cost of the insurance described in this section down to the NEMT/NEAT providers.

6.32.8.2 Automobile Liability

If the Contractor elects to contract with a Transportation Broker, the Contractor shall require its Transportation Broker to maintain, during the life of the contract between the Contractor and the Transportation Broker, Automobile Liability Insurance to protect the Contractor, LDH, the Transportation Broker and any Subcontractor or provider during the performance of work covered by the Contract or the contract between the Contractor and the Transportation Broker that shall have a minimum combined single limit per accident of one million dollars ($1,000,000). ISO form number CA 00 01 (current form approved for use in Louisiana), or equivalent, shall be used in the policy. This insurance shall include third-party bodily injury and property damage liability for owned, hired and non-owned automobiles.

6.32.9 Additional Requirements for NEMT Providers

6.32.9.1 Commercial General Liability

The Contractor or its Transportation Broker, if one is utilized, shall not require NEMT providers to maintain Commercial General Liability Insurance, unless such insurance is required by a local ordinance in areas where the NEMT

provider operates. The Contractor or its Transportation Broker shall ensure compliance by NEMT providers.

6.32.9.2 Automobile Liability

6.32.9.3 The Contractor or its Transportation Broker, if one is utilized, shall require their NEMT Providers to maintain, during the life of the Provider Agreement between the Transportation Broker and the NEMT Providers, Automobile Liability Insurance to protect the Contractor, LDH, the Transportation Broker, and the NEMT Providers during the performance of work covered by the Contract or the Provider Agreement that shall have coverage of twenty-five thousand dollars ($25,000) for bodily injury per person, fifty thousand dollars ($50,000) per accident, and twenty-five thousand dollars ($25,000) for property damages for NEMT Providers traveling in-state.

6.32.9.4 Workers' Compensation Indemnity

The Contractor or its Transportation Broker, if one is utilized, shall ensure that NEMT providers carry Workers' Compensation Insurance as required by Louisiana law.

6.32.10 Additional Requirements for Ambulance Providers

The Contractor or its Transportation Broker, if one is utilized, shall require all ambulance providers to maintain insurance, including, but not limited to, Medical Malpractice Liability, Automobile Liability, Commercial General Liability, and Workers' Compensation Indemnity, in accordance with La. R.S. 40:1135.9 and any applicable Federal or State law or local ordinance.

6.33 Duty to Defend

Upon notice of any claim, demand, suit, or cause of action against the State, alleged to arise out of or be related to this Contract, Contractor shall investigate, handle, respond to, provide defense for, and defend at its sole expense, even if the claim, demand, suit, or cause of action is groundless, false, or fraudulent. The State may, but is not required to, consult with or assist the Contractor, but this assistance shall not affect the Contractor's obligations, duties, and responsibilities under this section. Contractor shall obtain the State's written consent before entering into any settlement or dismissal.

6.34 Liability and Indemnification

6.34.1 Contractor Liability

Contractor shall be liable without limitation for any and all injury, death, damage, loss, destruction, damages, costs, fines, penalties, judgments, forfeitures, assessments, expenses (including attorney fees), obligations, and other liabilities of every name and

description, which may occur or in any way arise out of any act or omission of Contractor, its owners, partners, officers, directors, agents, employees, agents, or Subcontractors.

6.34.2 Force Majeure

6.34.2.1 It is understood and agreed that neither party can foresee the exigencies beyond the control of each party which arise by reason of an Act of God or force majeure; therefore, neither party shall be liable for any delay or failure in performance beyond its control resulting from an Act of God or force majeure. The State shall determine whether a delay or failure results from an Act of God or force majeure based on its review of all facts and circumstances.

6.34.2.2 The Contractor shall, however, be responsible for the development and implementation of a Continuity of Operations Plan as specified in the Continuity of Operations Plan section of this Contract. Notwithstanding the preceding, as long as this Contract remains in full force and effect, the Contractor shall be liable for the MCO Covered Services required to be provided or arranged for in accordance with this Contract and the Contractor's approved Continuity of Operations Plan.

6.34.3 Indemnification

6.34.3.1 Contractor shall fully indemnify and hold harmless the State, without limitation, for any and all injury, death, damage, loss, destruction, damages, costs, fines, penalties, judgments, forfeitures, assessments, expenses (including attorney fees), obligations, and other liabilities of every name and description, that may occur or in any way arise out of any act or omission of Contractor, its owners, partners, officers, directors, employees, or Subcontractors, including, but not limited to:

6.34.3.1.1 Sanctions on Network Providers and Enrollees, including, but not limited to, termination or exclusion from the Network, in accordance with provisions in the *Fraud, Waste, and Abuse Prevention Section*.

6.34.3.1.2 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 laws or regulations.

6.34.3.1.3 Failure to comply with applicable Federal or State laws, including, but not limited to, Medicaid laws and regulations, labor laws, and minimum wage laws.

6.34.3.1.4 Noncompliance with any judgment, settlement, court order, or consent decree, for which the responsibility for compliance has been delegated to the Contractor by LDH.

6.34.3.1.5 Failure to provide records to LDH in accordance with the public records' request requirements in the *Administration and Contract Management* section.

6.34.3.2 The Contractor shall not indemnify for the portion of any loss or damage arising from the State's act or failure to act.

6.34.4 Intellectual Property Indemnification

6.34.4.1 Contractor shall fully indemnify and hold harmless the State, without limitation, from and against any and all damages, costs, fines, penalties, judgments, forfeitures, assessments, expenses (including attorney fees), obligations, and other liabilities of every name and description that may be assessed against the State in any action for infringement of any intellectual property right, including but not limited to, trademark, trade-secret, copyright, and patent rights.

6.34.4.2 When a dispute or claim arises relative to a real or anticipated infringement, the Contractor, at its sole expense, shall submit information and documentation, including formal patent attorney opinions, as required by the State.

6.34.4.3 If the use of the product, material, service, or any component thereof is enjoined for any reason or if the Contractor believes that it may be enjoined, the Contractor, while ensuring appropriate migration and implementation, data integrity, and minimal delays of performance, shall at its sole expense and in the following order of precedence: (i) obtain for the State the right to continue using such product, material, service, or component thereof; (ii) modify the product, material, service, or component thereof so that it becomes a non-infringing product, material, or service of at least equal quality and performance; (iii) replace the product, material, service, or component thereof so that it becomes a non-infringing product, material, or service of at least equal quality and performance; or, (iv) provide the State monetary compensation for all payments made under the Contract related to the infringing product, material, service, or component, plus for all costs incurred to procure and implement a non-infringing product, material, or service of at least equal quality and performance. Until this obligation has been satisfied, the Contractor remains in default.

The Contractor shall not be obligated to indemnify that portion of a claim or dispute based upon the State's unauthorized: i) modification or alteration of the product, material or service; ii) use of the product, material or service in combination with other products not furnished by Contractor; or, iii) use of the product, material or service in other than the specified operating conditions and environment.

6.34.5 Limitations of Liability

The Contractor shall not be liable for incidental, indirect, special, or consequential damages, unless otherwise specifically enumerated herein, or in a resulting task order or

purchase order mutually agreed upon between the parties. In no circumstance shall the State be liable for incidental, indirect, special, or consequential damages; lost profits; lost revenue; or lost institutional operating savings.

6.34.6 Other Remedies

If the Contractor fails to perform in accordance with the terms and conditions of this Contract, or if any lien or claim for damages, penalties, costs and the like is asserted by or against the State, then, upon notice to the Contractor, the State may pursue all remedies available to it at law or equity, including retaining monies from amounts due the Contractor and proceeding against any surety of the Contractor.

6.35 Actual Damages

6.35.1 The Contractor may be liable for actual damages, liabilities, costs, and expenses of every type or description that may be incurred by the State to the extent caused by Contractor's violation of this Contract, including, but not limited to:

6.35.1.1 All amounts for which the State may be liable in an action or claim for damages, whether through a settlement or through a judgment of a court of competent jurisdiction.

6.35.1.2 All fines, Monetary Penalties, or disallowances whether civil or criminal, imposed by HHS or by any other Federal or State government agency, and all other costs and expenses necessitated by compliance with any order or mandate of such agency.

6.35.1.3 All costs and expenses, legal and otherwise, incurred in connection with 6.36.1.1 and 6.36.1.2 above, including, but not limited to, attorney's fees.

6.35.1.4 All costs and expenses incurred for the provision of remedial or restorative services to individuals whose information was affected by the violation or to other affected parties.

6.35.1.5 All costs and expenses that the State may be required to incur in order to procure another contractor to complete any work that Contractor performed in a non-compliant manner or failed to complete successfully in accordance with the terms of the Contract. For purposes of the preceding sentence, "costs and expenses that the State may be required to incur" means either (a) the final amount as determined by mutual written agreement of the parties following a negotiation of such costs and expenses, or, in the event that the parties are not able to reach such agreement (b) the finally judicially awarded amount, if any, by which the reasonable fees that the State is required to pay, and actually pays, to an alternative service provider to perform the terminated Services (or any portion(s) of such terminated services) not performed by Contractor as of the effective date of termination of such services exceeds the fees that

the State would otherwise have paid to Contractor pursuant to this Contract to perform such services.

6.36 Hold Harmless as to Enrollees

6.36.1 Notwithstanding State Plan approved cost sharing, the Contractor hereby agrees not to bill, charge, collect a deposit from, seek cost sharing or other forms of compensation, remuneration or reimbursement from, or have recourse against, Enrollees, or persons acting on their behalf, for MCO Covered Services that are rendered to such Enrollees by the Contractor and its Subcontractors.

6.36.2 The Contractor further agrees that the Enrollee shall not be held liable for payment for MCO Covered Services furnished under a Network Provider Agreement, referral, or other arrangement, to the extent that those payments would be in excess of the amount that the Enrollee would owe if the Contractor provided the service directly. The Contractor agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by the Contractor and insolvency of the Contractor.

6.36.3 The Contractor further agrees that the Enrollee shall not be held liable for the costs of any and all services provided by a provider whose service is not covered by the Contractor or who does not obtain Timely approval or required prior-authorization.

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

6.37 Loss of Federal Financial Participation (FFP)

The Contractor hereby agrees to be liable for any loss of FFP suffered by LDH due to the Contractor's, Providers' or its Subcontractors' actions or inactions, including, but not limited to, failure to perform the services as required under this Contract. Payments provided for under this Contract shall be denied for new Enrollees when, and for so long as, payment for those Enrollees is denied by CMS in accordance with the requirements in 42 CFR §438.730. CMS may deny payment to the State for new Enrollees if its determination is not Timely contested by the Contractor.

6.38 Interest

Interest generated through investments made by the Contractor shall be the property of the Contractor and shall be used at the Contractor's discretion.

6.39 Misuse of Symbols, Emblems, or Names in Reference to Medicaid

The Contractor may not use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems the words "Louisiana Medicaid" or "Louisiana Department of Health" or "Department of Health" or "LDH" or "Bureau of Health Services Financing" unless prior written approval is obtained from LDH. Specific written authorization from

LDH is required to reproduce, reprint, or distribute any LDH form, application, or publication for a fee. State and local governments are exempt from this prohibition. A disclaimer that accompanies the inappropriate use of program or LDH terms does not provide a defense. Each piece of mail or information constitutes a violation.

6.40 National Provider Identifier (NPI)

The HIPAA Standard Unique Health Identifier regulations (45 CFR Part 162) require that all Covered Entities must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES).

6.41 Non-Waiver of Breach

The failure of LDH at any time to require performance by the Contractor of any provision of this Contract, or the continued payment of the Contractor by LDH, shall in no way affect the right of LDH to enforce any provision of this Contract; nor shall the waiver of any breach of any provision thereof be taken or held to be a waiver of any prior or subsequent breach of such provision or as a waiver of the provision itself. No provision of this Contract shall be waived, modified, or deleted except by the written agreement of the parties and approval of CMS, if applicable.

6.42 Political Activity

6.42.1 None of the funds, materials, property, or services provided directly or indirectly under this Contract shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the Hatch Act of 1939, as amended (5 U.S.C. §1501, et seq.), and regulations issued pursuant thereto.

6.42.2 Additionally, 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.

6.43 Prohibited Payments

Payment for the following shall not be made:

6.43.1 Organ transplants, unless the State Plan has written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to Enrollees.

6.43.2 Non-Emergency Services provided by or under the direction of an excluded individual.

6.43.3 Any amount expended for which funds may be not used under the Assisted Suicide Funding Restriction Act of 1997 (42 U.S.C. §14401, et seq.).

6.43.4 Any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Plan.

6.43.5 Any amount expended for home health care services unless the Contractor ensures that the provider meets the appropriate surety bond requirements.

6.44 Offer of Gratuities

By signing this Contract, the Contractor signifies that no member of, or a delegate of, Congress, nor any elected or appointed official or employee of the State of Louisiana, the Government Accountability Office, HHS, CMS, or any other Federal agency has or shall benefit financially or materially from this Contract. This Contract may be terminated if LDH determines, in its sole discretion that gratuities of any kind were offered to, or received by, any officials or employees of the State, its agents, or employees.

6.45 Record Ownership

6.45.1 All records, reports, documents and other material delivered or transmitted to Contractor by LDH shall remain the property of LDH, and shall be returned by Contractor to LDH, at Contractor's expense, at termination of this Contract.

6.45.2 All records, reports, documents, or other material related to this Contract and/or obtained or prepared by the Contractor in connection with the performance of the services contracted for herein shall become the property of the State.

6.45.2.1 Upon termination of this Contract for any reason, the Contractor shall return or destroy, as directed by LDH in writing, within thirty (30) Calendar Days of the effective date of termination, all PHI received from LDH, or created or received by the Contractor on behalf of LDH. This provision shall also apply to PHI that is in the possession of Subcontractors or agents of the Contractor. The Contractor shall not retain any copies of PHI.

6.45.2.2 In the event that the Contractor determines that returning or destroying PHI is not feasible, the Contractor shall provide to LDH notification of the conditions, within thirty (30) Calendar Days of the effective date of termination of the Contract, that make return or destruction not feasible. Upon a mutual determination that return or destruction of PHI is not feasible, the Contractor shall extend the protections of the Contract to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction not feasible, for so long as the Contractor maintains such PHI. If LDH does not agree with the Contractor that the return or destruction of PHI is not feasible, the Contractor shall return or destroy the PHI within thirty (30) Calendar Days of notification of LDH's determination.

6.45.3 All other records, reports, documents, or other material shall, upon request, be returned by the Contractor to the State, at the Contractor's expense, at termination or expiration of the Contract.

6.46 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 Contractor resulting from this Contract.

6.47 Record Retention

6.47.1 The Contractor shall retain, and require Subcontractors to retain, as applicable, financial records, supporting documents, statistical records, and all other records pertinent to an award, including, but not limited to Enrollee Grievance and Appeal records in 42 CFR §438.416; base data in 42 CFR §438.5(c); MLR reports in 42 CFR §438.8(k); and the data, information, and documentation specified in 42 CFR §438.604, §438.606, §438.608, and §438.610, shall be retained for a period of ten (10) years following the termination of the Contract. The only exceptions are the following:

6.47.1.1 If any litigation, claim, financial management review, or audit is started before the expiration of the ten (10) year period, the records shall be retained until all litigation, claims, or audit findings involving the records have been resolved and final action taken;

6.47.1.2 Records for real property and equipment acquired with Federal funds shall be retained for ten (10) years after final disposition;

6.47.1.3 When records are transferred to or maintained by LDH, the ten (10) year retention requirement is not applicable to the Contractor; and

6.47.1.4 Indirect cost rate proposals, cost allocations plans, etc., as specified in 45 CFR §75.361(f).

6.47.2 Under no circumstances shall the Contractor or any of its Material Subcontractors destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

6.48 Reporting Changes

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

6.48.1 Change in business address, telephone number, facsimile number, and e-mail address;

6.48.2 Change in corporate status or nature;

6.48.3 Change in business location;

6.48.4 Change in solvency;

6.48.5 Change in corporate officers, executive employees, or corporate structure;

6.48.6 Change in ownership, including but not limited to the new owner's legal name, business address, telephone number, facsimile number, and e-mail address;

6.48.7 Change in incorporation status;

6.48.8 Change in Federal employee identification number or Federal tax identification number; and/or

6.48.9 Change in Contractor litigation history, current litigation, audits and other government investigations both in Louisiana and in other states related to the delivery of managed care benefits.

6.49 Right to Audit

6.49.1 LLA, LDH, internal auditors of the Division of Administration, CMS, OIG, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Contractor, or its Subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted.

6.49.2 The right to audit under this section exists for ten (10) years from the final date of the contract term or from the date of completion of any audit, whichever is later.

6.49.3 Records shall be made available during Business Hours for this purpose.

6.50 Severability

If any provision of this Contract is declared or found to be illegal, unenforceable, or void by a judgment or order of a court of competent jurisdiction, then both LDH and the Contractor shall be relieved of all obligations arising under such provision. If the remainder of this Contract is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed. In addition, if the laws or regulations governing this Contract should be amended or judicially interpreted as to render the fulfillment of the Contract impossible or economically infeasible, both LDH and the Contractor will be discharged from further obligations created under the terms of the Contract.

6.51 Software Reporting Requirement

All reports submitted to LDH by the Contractor shall be in a format accessible and modifiable by the standard Microsoft Office Suite of products, Version 2007 or later, or in a format accepted and approved by LDH.

6.52 Termination

6.52.1 Termination for Convenience

LDH may terminate this Contract at any time without penalty by giving sixty (60) Calendar Days' written notice to the Contractor of such termination or negotiating an effective date with the Contractor. The Contractor shall be entitled to payment for deliverables in progress, to the extent work has been performed satisfactorily.

6.52.2 Termination Due to Serious Threat to Health of Enrollees

LDH may terminate this Contract immediately if LDH determines, in its sole discretion, that actions by the Contractor, its Subcontractor(s), or Provider(s) pose a serious threat to the health of its Enrollees.

6.52.3 Termination for Insolvency, Bankruptcy, or Instability of Funds

6.52.3.1 The Contractor's insolvency or the filing of a petition in bankruptcy by or against the Contractor shall constitute grounds for termination for cause. If LDH determines, in its sole discretion, that the Contractor has become financially unstable, LDH shall immediately terminate this Contract upon written notice to the Contractor effective the close of business on the date specified in such notice.

6.52.3.2 The Contractor shall cover continuation of services to Enrollees for any period for which payment has been made, as well as for inpatient admissions up until discharge.

6.52.4 Termination for Ownership Violations

The Contractor is subject to termination for cause, unless the Contractor can demonstrate changes of ownership or control, when:

6.52.4.1 A person with a direct or indirect ownership interest in the Contractor:

6.52.4.1.1 Has been convicted of a criminal offense under 42 U.S.C. §1320a-7(a), (b)(1) or (3), in accordance with 42 CFR §1002.203.

6.52.4.1.2 Has had civil Monetary Penalties or assessments imposed under 42 U.S.C. §1320a-7a.

6.52.4.1.3 Has been excluded from participation in Medicare or any State health care program.

6.52.4.2 Any individual who is an Affiliate or an officer (if the Contractor is organized as a corporation), or who is a partner (if it is organized as a partnership), or who is an agent or a managing employee, is under temporary management as defined in the *Contract Non-Compliance* section.

6.52.4.3 The Contractor has a direct or indirect substantial contractual relationship with an excluded individual or entity.

6.52.5 Termination for Non-Appropriation of Funds

6.52.5.1 The continuation of this Contract shall be contingent upon the appropriation of funds by 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 of Title 39 of the Louisiana Revised Statutes of 1950 to

prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the Contract, the Contract shall terminate without penalty on the date of the beginning of the first fiscal year for which funds have not been appropriated.

6.52.6 Termination for Unavailability of Federal Funds

6.52.6.1 The continuation of this Contract shall be contingent upon the availability of Federal funds to fulfill the requirements of the Contract. If Federal funds become unavailable during the term of this Contract, LDH may terminate the Contract without penalty. Availability of funds shall be determined solely by LDH. LDH shall notify the Contractor of the unavailability of Federal funds in writing and the date upon which the Contract shall terminate.

6.52.7 Termination of the Contract for Cause

6.52.7.1 Except as otherwise provided for herein, LDH may terminate the Contract for cause based upon the failure of the Contractor to comply with the terms and/or conditions of the Contract; provided LDH shall give the Contractor written notice specifying the Contractor's failure. If within thirty (30) Calendar Days after receipt of such notice, the Contractor shall not have either corrected such failure or, in the case of failure that cannot be corrected in thirty (30) Calendar Days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction, then LDH may, at its option, place the Contractor in default and the Contract shall terminate on the date specified in such notice. Failure to perform within the time agreed upon in the Contract may constitute default and may result in termination of the Contract.

6.52.7.2 The Contractor may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of LDH to comply with the terms and conditions of the contract provided that the Contractor shall give LDH written notice specifying LDHs failure and a reasonable opportunity for LDH to cure the defect.

6.52.8 The Contractor has the duty to fully cooperate with the State and provide any and all requested information, documentation, etc. at its earliest convenience to the State when requested. This applies even if the contract is terminated and/or a lawsuit is filed. Specifically, the Contractor does not have the right to limit or impede the State's right to audit or to withhold State-owned documents.

6.53 Headings

Headings to sections are included for the purpose of convenient reference and shall have no force or effect upon the construction or interpretation of any provision of the Contract.

6.54 Withholding in Last Month of Payment; Offsets Against Future Payments Under a New Contract

For the last month of the Contract, LDH shall withhold seventy-five percent (75%) of the final payment to the Contractor for a maximum of one hundred eighty (180) Calendar Days from the due date of such amount. LDH may retain and offset this withhold if the Contractor does not fulfill its contractual obligations, some of which may extend past the term of the Contract, including, but not limited to, paying LDH any outstanding Monetary Penalties and sanctions assessed during the term of the Contract, paying LDH any Monetary Penalties and sanctions assessed after the term of the Contract for any Contractor noncompliance that occurred during the term of the Contract, or repaying LDH for payments made on behalf of ineligible Enrollees.

Should LDH identify Contractor non-compliance with any provisions of the Contract after termination or expiration of the Contract and Contractor and LDH have entered into a new contract for MCO services, LDH may offset any such Monetary Penalties and sanctions against future payments to Contractor. Penalties for Contractor noncompliance that occurred partially during the term of the Contract and partially during the term of the new contract for MCO services shall be assessed in accordance with the terms of the Contract for the entirety of the noncompliance. Any notice requirements by LDH, and Contractor dispute rights relating to the Monetary Penalties and/or payment offsets, shall be in accordance with the terms of the Contract.

6.55 Hudson/Veterans Initiative Reporting

During the term of the Contract and at expiration, the Contractor will be required to report Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurship Subcontractor participation and the dollar amount of each.

MCO Amendment 12
Attachment C12 – Changes to Attachment C, *In Lieu of Services*

Item	Change From	Justification
1	See redlined Attachment C. Physical Health – Doula Services	This revision is required because House Bill 454 of the 2025 Regular Legislative Session requires Medicaid coverage of doula services. This revision removes doula services as an "in lieu of service."

LOUISIANA DEPARTMENT OF HEALTH

Medicaid Managed Care Organization Contract
Attachment C: In Lieu of Services

The Contractor may, at its option, cover the approved services or settings for Enrollees in lieu of Medicaid State Plan services as provided in this Attachment. Requirements and policies for in lieu of services are provided in the Contract and the MCO Manual.

Physical Health

Name and Description	Covered Medicaid State Plan Service or Setting for which each ILOS is a substitute	Clinically oriented definition(s) for the target population(s) for each ILOS	Specific coding for each ILOS to be used on claims and encounter data	Effective Date under Current Contract	Original Effective Date
Chiropractic services for adults age 21 and older The purpose of this ILOS is to provide coverage of chiropractic services to diagnose and treat neuromusculoskeletal conditions associated with the functional integrity of the spine. Services include evaluation and management services, x-rays, spinal manipulation, and other treatments.	Inpatient hospitals, outpatient hospitals, physician services, nurse practitioner services, other licensed practitioners' services, laboratory and x-ray services, prescribed drugs	Enrollees age 21 and older	99202 thru 99205 (E/M new pt); 99212 thru 99215 (E/M estab. pt); 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114, 72120, 72220 (X Rays); 98940, 98941, 98942 (spinal manipulation); 97012, 97014, 97022, 97035, 97032,97110,	1/1/2023	1/1/2022

			97112, 97116, 97124, 97140 (other treatments); 20560, 20561 (dry needling)		
Hospital-based care coordination for pregnant and postpartum individuals with substance use disorder and their newborns The purpose of this ILOS is to provide coverage of a comprehensive pregnancy medical home model of care to enrollees with substance use disorder (SUD) who are pregnant or postpartum. The model includes care coordination, health promotion, individual and family support, and linkages to community/support services, behavioral, and physical health services. The model does not include coverage of physical and behavioral health services otherwise covered under the Louisiana Medicaid State Plan (e.g., outpatient OB care, SUD treatment services). In addition, this ILOS is not duplicative of MCO case management services. This ILOS will not serve as a substitute for medically necessary physical and behavioral health services such as obstetrical care or SUD care. Rather, the ILOS will help to ensure that enrollees receive comprehensive physical and behavioral health care services that meet their needs, while avoiding preventable use of acute care.	Inpatient hospitals, outpatient hospitals, physician services, nurse practitioner services, other licensed practitioners' services	Enrollees with substance use disorder (SUD), who are pregnant and age 18 or older or up to 12 months postpartum, and their newborns	H0002(alcohol and drug screening); H0006(alcohol and drug tx services); H0023 (alcohol and drug tx outreach/BH services)	1/1/2023	1/1/2022
~~Doula Services~~ ~~The purpose of this ILOS is to offer pregnant enrollees adjunctive services that encourage and support healthy childbirth experiences through support of pregnant persons before, during, and after childbirth. Support also may include birthing, lactation, and parenting classes. Reduction in adverse birth outcomes is the primary goal of this program by supporting birthing persons~~	~~Inpatient and outpatient hospital services~~	~~Pregnant and postpartum women~~	~~S9443: Lactation Class S9442: Birthing Class S9443: Lactation Class S9444: Parenting Class S9445: Pre/post-~~	~~1/1/2023~~	~~1/1/2022~~

~~through the use of doulas that are trained and dedicated to providing physical, emotional, and informational support during the childbirth period. Doulas augment routine prenatal care by assuring that members receive safe, healthy, and equitable prenatal and postnatal health care.~~			~~natal Doula visits~~ ~~99199: Attendance at Vaginal Delivery by Doula~~ ~~99404: Preventive Medicine Counseling/Post/Natal Nurse Advocacy~~ ~~(Billing provider type DL/1W and/or Rendering Provider Type DL/IV)~~		
Remote Patient Monitoring Remote patient monitoring (RPM) means digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment, recommendations, and interventions. RPM devices include (1) non-invasive remote monitoring devices that measure or detect common physiological parameters, and (2) non-invasive monitoring devices that wirelessly transmit the beneficiary's medical information to their health care provider or other monitoring entity. The device must be reliable and valid, and the beneficiary must be trained or sufficiently knowledgeable in the proper use/wearing of the device to ensure appropriate recording of medical information. Medical information may include, but is not limited to, blood pressure and heart rate and rhythm monitoring for members with hypertension and blood glucose control for members with diabetes. Members enrolled should have smart phone or tablet access and connectivity for data reporting.	Physician services (office visits), emergency services, and inpatient hospitals	Members with hypertensive disorders and/or diabetes, ages 18-75 (HEDIS), with the following characteristics: • Members with hypertension and a PPA/PPR/PPV* event within the last 18 months. • Members with diabetes and a PPA/PPR/PPV events within last 18 months • Poorly controlled hypertension (>140/90), at risk for PPA/PPR/PPV • Poorly controlled diabetes (HbA1c >9.0%), at risk for PPA/PPR/PPV • Smart phone or tablet access Pregnant women with hypertensive disorders and/or diabetes, ages 16-50, with the following characteristics: • Poorly controlled hypertension (>140/90)	99453 (setting up remote patient monitoring); 99454 (remote monitoring of physiologic parameters); 99199 (unlisted service) with appropriate modifiers: may be used as an alternative reimbursement CPT code for systems that have conflict with use of 99454)	7/1/2023	7/1/2023

		• Insulin dependent diabetes in pregnancy • Smart phone or tablet access			
Outpatient Lactation Support	Physician services, outpatient hospital services.	Any Enrollee who is pregnant, breastfeeding, or expressing breastmilk for the purposes of providing nutrition to an infant.	S9445, modifier 33 S9443	1/1/2024	1/1/2024
Care at Home The purpose of this ILOS is to provide ordered treatment, at home, for enrollees with chronic disease who are experiencing an acute exacerbation of their illness. This is not intended as emergency care, but urgent care for enrollees who are physically unable to reach their provider and may otherwise necessitate emergency transport for care. Providers refer their patient for an at home scheduled visit when a virtual care or an in-office visit is not appropriate to address the enrollee's acute chronic health needs. An in-home care provider, either an EMT or paramedic, depending on need, is sent to the member's residence within 24 hours to facilitate treatment and symptom management, reducing unnecessary ED use and hospitalizations. Communication and coordination of care is arranged with the referring Provider.	Emergency ambulance, emergency department	Medicaid-eligible members aged 13 and up, with chronic disease, with acute needs and unable to access office visit or virtual visit.	99342 99344 99345 99348 99349 99350 99417 E&M codes 99211-99215	7/1/2024	7/1/2024

Behavioral Health

Name and Description	Covered Medicaid State Plan Service or Setting for which each ILOS is a substitute	Clinically oriented definition(s) for the target population(s) for each ILOS	Specific coding for each ILOS to be used on claims and encounter data	Effective Date under Current Contract	Original Effective Date
23-Hour observation bed services for adults age 21 and older 23-hour observation offers an alternative to an unwarranted inpatient psychiatric hospitalization admission by providing 23-	Inpatient psychiatric hospitals	Medicaid-eligible adults 21+, presenting in a crisis.	G0379, 99218,99219,99220, 99234,99235,99236	1/1/2023	12/1/2015

Name and Description	Covered Medicaid State Plan Service or Setting for which each ILOS is a substitute	Clinically oriented definition(s) for the target population(s) for each ILOS	Specific coding for each ILOS to be used on claims and encounter data	Effective Date under Current Contract	Original Effective Date
hour crisis respite and observation in a secure setting. This service is aimed for members who are voluntarily admitting for less than 24 hours due to sub-imminent crisis stabilization which is currently not available in every region. This service attempts to prevent psychiatric/psychologic impairments through rapid stabilization thus leading to the sooner return of functional independence.					
Freestanding psychiatric hospitals for adults ages 21-64 The purpose of this alternative service is to assist adult Medicaid members with significant behavioral health challenges. This population would be treated in more expensive general hospital psych units without this service. This creates access issues as beds in general hospitals are limited. Multiple downstream issues occur as a result. Consumers must remain in emergency departments while waiting for available beds. Costs increase to the healthcare system as members utilize those medical resources while awaiting beds in general hospitals. Use of free standing psych units reduces Emergency Department consumption, increases psychiatric bed capacity and provides a less costly alternative to general hospital beds.	General hospital psychiatric units	Medicaid-eligible adults, with significant behavioral health challenges, ages 21-64 years, with the following characteristics: Any adult that would have previously required treatment in general hospital psych units.	Rev Codes - 100, 114, 116, 124, 126, 134, 136,144, 146, 154, 156, 204 S9480, 124',126 00400P2, 00400QX, 00560QK, 01830QK, 90792, 90870, H0011SE, H0011TG, H0015HB, H0015HM,H0015HO, H0015HQ, H0039HB, H2034HB, H2036, H2036HB, H2036SE, H2036TG Provider Specialty (PS)/Provider Type: (PT)"PS = 86, PT = 64	1/1/2023	12/1/2015
Injection services provided by licensed nurses to adults age 21 and older This service allows licensed nurses to provide injectable medications to adult Medicaid members. Many members are	Physician services	Medicaid-eligible adults ages 21 who have outpatient medication needs requiring injectable medications, as opposed to oral intake. Members who have tried and failed on oral psychotropics or their mental status	99201-99215, 96372, 96372, 99070, J0400, J1630, J1631, J2060, J2315,	1/1/2023	12/1/2015

Name and Description	Covered Medicaid State Plan Service or Setting for which each ILOS is a substitute	Clinically oriented definition(s) for the target population(s) for each ILOS	Specific coding for each ILOS to be used on claims and encounter data	Effective Date under Current Contract	Original Effective Date
unable or unwilling to take oral psychotropics or their mental status indicates a need for injectable meds to assure compliance and stability. The objective of adding Licensed Nurses is to fill in this services delivery method to aid members to receive medications in the most efficient and least costly manner possible, and at the same time increasing compliance, reducing subsequent office visits, and reducing hospitalizations resulting from decompensation.		indicates a need for injectable meds to assure compliance and stability.	J2358, J2426, J2794, J3310, J3360, J3486		
Mental Health (MH) Intensive Outpatient Programs (IOP) The purpose of this ILOS is to provide enrollees treatment via the least restrictive level of care, allowing an alternative to inpatient hospitalization or Assertive Community Treatment and providing a step-down option from inpatient hospitalization for enrollees at high risk for readmission.	Inpatient hospitalization or Assertive Community Treatment	Medicaid Eligible Members, Age 12+, who are at risk for inpatient hospitalization for a psychiatric condition, or members needing a step down from an inpatient hospitalization that is a higher level than standard outpatient services.	S9480, S9480HB, H0015	1/1/2023	9/14/2018
Population Health Management Program Mindoula Clinical Services, P.C.'s Population Health Management Program ("PHMP") is a precision solution that targets, engages, and serves members with Serious Mental Illness ("SMI"), Substance Use Disorder ("SUD") and/or members with Sickle Cell Disease ("SCD") and other comorbid medical conditions through team-based, tech-enabled, care extension services. This focused approach includes (1) identification of members for the PHMP using proprietary algorithms and member archetype data, (2) outreach and enrollment of members using an intake process specific to SMI, SUD and SCD populations, and (3) provision of tech-enabled programmatic interventions that include content and methods tailored to reducing total costs of care by addressing	Emergency services, inpatient hospitals	Members with Serious Mental Illness (SMI), Substance Use Disorder (SUD) and/or Sickle Cell Disease (SCD) living in Louisiana, ages 18+, who have a diagnosis of Schizophrenia, Major Depressive Disorder, Bipolar Disorder, and other SMI, with or without substance use, and members with SCD who have not engaged with outpatient care and experience repeated behavioral health-related hospitalizations and/or visits to the emergency department because of poorly treated/controlled behavioral health symptoms. Most of these members have either refused case management services or cannot be contacted.	99490	1/1/2023	1/5/2022

Name and Description	Covered Medicaid State Plan Service or Setting for which each ILOS is a substitute	Clinically oriented definition(s) for the target population(s) for each ILOS	Specific coding for each ILOS to be used on claims and encounter data	Effective Date under Current Contract	Original Effective Date
behavioral, medical, and social needs specific to SMI, SUD and SCD populations.					
Therapeutic Day Center for ages 5-20 The Center for Resilience is a therapeutic day center which provides educational and intensive mental health supports in an innovative partnership with the Tulane University Medical School Department of Child and Adolescent Psychiatry to ensure the emotional well-being and academic readiness of children with behavioral health needs. Children receive instructional, medical, and therapeutic services at the day program site with the goal of building the skills necessary to successfully transition back to the traditional school setting. Center for Resilience provides a caring, non-punitive, therapeutic milieu with positive behavioral supports, trauma-informed approaches, evidence-based mental health practices, small-group classroom instruction, and therapeutic recreation activities. The leadership team is comprised of clinicians, educators, and medical doctors, and the therapeutic milieu is a result of this intentionally interdisciplinary collaboration. The goal of this ILOS is to reduce incidents of crisis hospitalization and residential psychiatric care.	Inpatient psychiatric hospitals, psychiatric residential treatment facility (PRTF)	Children and adolescents with behavioral health diagnoses, 5 to <21, with the following characteristics: • PTSD, anger, depression, mood disorders, developmental disabilities, learning disabilities, psychosisHigh risk behaviors & juvenile justice-involvement Unresponsive to school and agency/MHR intervention	G0177 or H0035	7/1/2023	7/1/2023
Integrated Behavioral Health Homes Integrated Behavioral Health Homes (IBHH) is a value-based program that furthers alternative payment methodologies and integration by improving medical, behavioral, and social healthcare outcomes for participants while decreasing the overall total cost of care. MCOs who offer this ILOS will contract with qualified providers to deliver the six core services that are central to Medicaid health homes, as outlined by the ACA and endorsed	Inpatient psychiatric hospitals, psychiatric residential treatment facility (PRTF)	Medicaid and dual eligible beneficiaries, all ages, with the following characteristics: Members with SMI, SED and/or SUD diagnoses who have complex medical comorbidities and high utilization of ER/ED, Medical IP, or Behavioral IP/Residential care	G9002	7/1/2023	7/1/2023

Name and Description	Covered Medicaid State Plan Service or Setting for which each ILOS is a substitute	Clinically oriented definition(s) for the target population(s) for each ILOS	Specific coding for each ILOS to be used on claims and encounter data	Effective Date under Current Contract	Original Effective Date
by CMS, Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Council for Mental Wellbeing: • Comprehensive care management; • Care coordination; • Health promotion; • Comprehensive transitional care and follow-up; • Patient and family support; and • Referrals to community and social support services. The eligible population will be identified by the MCO and assigned to the participating providers within the eligible population's geographical area. This is an opt-in model and does not require enrollees to change or adjust any of their existing provider relationships.					
Visions of Hope Community Services The Visions of Hope Community Services program is a comprehensive and intensive service bundling for high-risk, low-functioning individuals with severe and persistent mental illness. This model addresses whole person care that combines behavioral health while addressing social determinants of health and providing physical health coordination and support. The VOH-CS program serves individuals who would have difficulty navigating services across multiple, disconnected providers and thus are at greater risk of hospitalization, homelessness, substance use, victimization and incarceration. This model offers daily socialization opportunities for this population who might not interact socially with their peers in other settings.	Inpatient psychiatric hospitalization, Assertive Community Treatment Program, and Emergency Room Visits	Region 7 members 18 years or older who have a severe and persistent mental illness (SPMI) with or without a co-occurring disorder that is seriously impairing their functioning within the community as evidenced by a LOCUS of 3 or higher	H2022	7/1/2024	7/1/2024

LOUISIANA DEPARTMENT OF HEALTH

MCO Amendment 12
Attachment F12 – Changes to Attachment F, *Provider Network Standards*

<table>
<tr><th>Item</th><th>Change From</th><th>Change To</th><th>Justification</th></tr>
<tr><td>1</td><td>
<table>
<tr><th colspan="3">Substance Abuse and Alcohol Abuse Center - Outpatient</th></tr>
<tr><td>ASAM Level 1</td><td>30</td><td>15</td></tr>
<tr><td>ASAM Level 2.1</td><td>30</td><td>15</td></tr>
<tr><td>ASAM Level 2WM</td><td>60</td><td>60</td></tr>
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<table>
<tr><th colspan="3">Substance Abuse and Alcohol Abuse Center – Outpatient (adult[5])</th></tr>
<tr><td>ASAM Level 1.5</td><td>30</td><td>15</td></tr>
<tr><td>ASAM Level 2.1</td><td>30</td><td>15</td></tr>
<tr><td>ASAM Level ~~2WM~~ 2.7</td><td>60</td><td>60</td></tr>
<tr><th colspan="3">Substance Abuse and Alcohol Abuse Center - Outpatient (pediatric[5])</th></tr>
<tr><td>ASAM Level 1</td><td>30</td><td>15</td></tr>
<tr><td>ASAM Level 2.1</td><td>30</td><td>15</td></tr>
<tr><td>ASAM Level 2WM</td><td>60</td><td>60</td></tr>
</table>
</td><td>Revisions are necessary to comply to reflect the planned transition with the American Society of Addiction Medicine (ASAM) 4th Edition standards. This change is necessary to align contractual obligations with recent budget approval received to support statewide implementation of the updated ASAM criteria, effective January 1, 2026.</td></tr>
<tr><td>2</td><td>
<table>
<tr><th colspan="3">Substance Use Residential Treatment Facilities (adult[5])</th></tr>
<tr><td>ASAM Levels 3.1</td><td>30</td><td>30</td></tr>
<tr><td>ASAM Levels 3.3</td><td>30</td><td>30</td></tr>
<tr><td>ASAM Levels 3.5</td><td>30</td><td>30</td></tr>
<tr><td>ASAM Levels 3.2 –Withdrawal Management</td><td>60</td><td>60</td></tr>
<tr><td>ASAM Level 3.7</td><td>60</td><td>60</td></tr>
<tr><td>ASAM Level 3.7-Withdrawal Management</td><td>60</td><td>60</td></tr>
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<tr><td>ASAM Levels 3.1</td><td>30</td><td>30</td></tr>
<tr><td>~~ASAM Levels 3.3~~</td><td>~~30~~</td><td>~~30~~</td></tr>
<tr><td>ASAM Levels 3.5</td><td>30</td><td>30</td></tr>
<tr><td>~~ASAM Levels 3.2 –Withdrawal Management~~</td><td>~~60~~</td><td>~~60~~</td></tr>
<tr><td>ASAM Level 3.7</td><td>60</td><td>60</td></tr>
<tr><td>ASAM Level 3.7-Withdrawal Management</td><td>60</td><td>60</td></tr>
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<tr><td>3</td><td>
<table>
<tr><th>Type of Visit/Admission/Appointment</th><th>Access/Timeliness Standard</th></tr>
<tr><td>ASAM Level 3.3, 3.5 & 3.7</td><td>10 business days</td></tr>
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</td><td>
<table>
<tr><th>Type of Visit/Admission/Appointment</th><th>Access/Timeliness Standard</th></tr>
<tr><td>ASAM Level ~~3.3,~~ 3.5 & 3.7</td><td>10 business days</td></tr>
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</table>

Item	Change From			Change To			Justification
4	**Specialty Care**			**Specialty Care**			Revision are necessary to remove Specialty Care due to the inability to track all BH specialty care by provider type and/or specialty in GeoAccess mapping. Also, revisions included combining distance standards because both provider types make up specialty care.
	Physicians and LMHPs who specialize in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related	60	60	Physicians and LMHPs who specialize in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related	**60**	**60**	
	Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders	60	60	Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders			
	Other Specialty Care	60	60	~~Other Specialty Care~~	~~60~~	~~60~~	
5	**Licensed Mental Health Specialists**[7, 9]			**Licensed Mental Health ~~Specialists~~ Practitioners**[7, 9]			Revisions are necessary to include Licensed Mental Health Specialists and to add allowable provider types to mimic language used in the Behavioral Health Services Provider Manual. Also, revisions included combining distance standards because all provider types make up Licensed Mental Health Specialists.
	Advanced Practice Registered Nurse (Nurse Practitioners and Clinical Nurse Specialists with a behavioral health specialty)	30	15	Advanced Practice Registered Nurse (Nurse Practitioners and Clinical Nurse Specialists with a behavioral health specialty)	**30**	**15**	
	Medical or Licensed Psychologist	30	15	Medical or Licensed Psychologist			
	Licensed Clinical Social Worker	30	15	Licensed Clinical Social Worker			
				Licensed Professional Counselor			
				Licensed Marriage and Family Therapist			
				Licensed Master Social Worker			
				Provisionally Licensed Professional Counselor			
				Provisionally Licensed Marriage and Family Therapist			
6	**Psychiatric Residential Treatment Facilities (PRTFs) (pediatric**[5]**)**[9]			**Psychiatric Residential Treatment Facilities (PRTFs) (pediatric**[5]**)**[9]			Revisions are necessary to combined distance standards because all provider types make up Licensed Mental Health Specialists.
	Psychiatric Residential Treatment Facility	200	200	Psychiatric Residential Treatment Facility	**200**	**200**	
	Psychiatric Residential Treatment Facility Addiction (ASAM Level 3.7)	200	200	Psychiatric Residential Treatment Facility Addiction (ASAM Level 3.7)			
	Psychiatric Residential Treatment Facility Other Specialization	200	200	Psychiatric Residential Treatment Facility Other Specialization			

Item	Change From	Change To	Justification
7	**Psychiatric Inpatient Hospital Services[9]** Hospital, Free Standing Psychiatric Unit — 90 — 90 Hospital, Distinct Part Psychiatric Unit — 90 — 90	**Psychiatric Inpatient Hospital Services[9]** Hospital, Free Standing Psychiatric Unit Hospital, Distinct Part Psychiatric Unit **90** **90**	Revisions are necessary to combined distance standards because all provider types make up Licensed Mental Health Specialists.
8	**Behavioral Health Rehabilitation Services[9]** Mental Health Rehabilitation Agency (Legacy MHR) — 30 — 15 Behavioral Health Rehab Provider Agency (Non-Legacy MHR) — 30 — 15	**~~Behavioral~~ Mental Health Rehabilitation Services[9]** Mental Health Rehabilitation Agency ~~(Legacy MHR)~~ — 30 — 15 ~~Behavioral Health Rehab Provider Agency (Non-Legacy MHR)~~ — ~~30~~ — ~~15~~	Revision is necessary because Behavioral Health Rehab Provider Agency is no longer a provider type and has been removed (legacy MHR) as the Mental Health Rehabilitation Agency provider type applies to all MHRs.
9	Notes: [1] For the purposes of assessing Network Adequacy, the MCO shall consider only those Providers who are actively providing services to enrollees, which shall be defined as (1) physical health providers who have submitted at least twenty-five (25) claims in an office setting within the prior six (6) calendar months; (2) behavioral health providers who have submitted at least twenty-five (25) claims within the prior (six) calendar months; or (3) any providers who were newly contracted within the prior six (6) calendar months, regardless of claim submissions.	Notes: [1] For the purposes of assessing Network Adequacy, the MCO shall consider only those Providers who are actively providing services to enrollees, which shall be defined as (1) physical health providers who have submitted at least ~~twenty-five (25)~~ **one (1)** claim in an office setting within the prior ~~six (6)~~ **twelve (12)** calendar months; (2) behavioral health providers who have submitted at least ~~twenty-five (25)~~ **one (1)** claim within the prior ~~six (6)~~ **twelve (12)** calendar months; or (3) any providers who were newly contracted within the prior ~~six (6)~~ **twelve (12**) calendar months, regardless of claim submissions.	These revisions are necessary to update requirements related to Claim submissions.
10	Notes: [3] Unless otherwise specified in this Attachment, the Contractor must demonstrate that one hundred percent (100%) of applicable members (adult or pediatric) have access to Network Providers for the type of service specified within the identified distance standard from the Enrollee's residence, based on a driving route versus a straight line calculation.	Notes: [3] Unless otherwise specified in this Attachment, the Contractor must demonstrate that **ninety percent (90%)**~~one hundred percent (100%) of~~ applicable members (adult or pediatric) have access to Network Providers for the type of service specified within the identified distance standard from the Enrollee's residence, based on a driving route versus a straight line calculation.	Revision is necessary as 100% threshold is not realistic.

Medicaid Managed Care Organization Contract
Attachment F: Provider Network Standards

At a minimum, the Contractor's Provider Network must meet Contract Network Adequacy standards, including the ratio, distance, and timeliness of care standards in this Attachment.

Physical Health Access and Distance Standards

Type[1]	Network Ratio[2] (Provider: Member)	Rural Parishes[3] (miles)	Urban Parishes[3] (miles)
Primary Care[4]			
Adult[5] PCP (Family/General Practice; Internal Medicine; FQHC; RHC)[6]	1:1,000	30	10
Pediatric[5] PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC)[6]	1:1,000	30	10
Hospitals			
Acute Inpatient Hospitals		30	10
Ancillary			
Laboratory		30	20
Radiology		30	20
Pharmacy		30	10
Hemodialysis Centers		30	10
Home Health		60	60
Primary Dental Services[10]		30	10
Specialty Dental Services[10]		75	
Specialty Care			
OB/GYN[4]	1:10,000	30	15
Allergy/Immunology	1:100,000	60	60
Cardiology	1:20,000	60	60
Dermatology	1:40,000	60	60
Endocrinology and Metabolism[7]	1:25,000	60	60
Gastroenterology	1:30,000	60	60
Hematology/Oncology	1:80,000	60	60
Nephrology	1:50,000	60	60
Neurology[7]	1:35,000	60	60
Ophthalmology	1:20,000	60	60
Orthopedics[7]	1:15,000	60	60
Otorhinolaryngology/ Otolaryngology	1:30,000	60	60

Type[1]	Network Ratio[2] (Provider: Member)	Rural Parishes[3] (miles)	Urban Parishes[3] (miles)
Urology	1:30,000	60	60
Other Specialty Care		60	60

Behavioral Health Access and Distance Standards

Type[1]	Rural Parishes[3] (miles)	Urban Parishes[3] (miles)
Psychiatrists	30	15
Specialty Care		
Physicians and LMHPs who specialize in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related	60	60
Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders		
~~Other Specialty Care~~	~~60~~	~~60~~
Licensed Mental Health Practitioners[7, 9]		
Advanced Practice Registered Nurse (Nurse Practitioners and Clinical Nurse Specialists with a behavioral health specialty)	30	15
Medical or Licensed Psychologist		
Licensed Clinical Social Worker		
Licensed Professional Counselor		
Licensed Marriage and Family Therapist		
Licensed Master Social Worker		
Provisionally Licensed Professional Counselor		
Provisionally Licensed Marriage and Family Therapist		
Psychiatric Residential Treatment Facilities (PRTFs) (pediatric[5])[9]		
Psychiatric Residential Treatment Facility	200	200
Psychiatric Residential Treatment Facility Addiction (ASAM Level 3.7)		
Psychiatric Residential Treatment Facility Other Specialization		
Substance Abuse and Alcohol Abuse Center – Outpatient (adult[5])		
ASAM Level 1.5	30	15
ASAM Level 2.1	30	15
ASAM Level ~~2WM~~ 2.7	60	60
Substance Abuse and Alcohol Abuse Center - Outpatient (pediatric[5])		
ASAM Level 1	**30**	**15**
ASAM Level 2.1	**30**	**15**
ASAM Level 2WM	**60**	**60**
Substance Use Residential Treatment Facilities (adult[5])		
ASAM Levels 3.1	30	30
~~ASAM Levels 3.3~~	~~30~~	~~30~~
ASAM Levels 3.5	30	30

~~ASAM Levels 3.2 –Withdrawal Management~~	~~60~~	~~60~~
ASAM Level 3.7	60	60
ASAM Level 3.7-Withdrawal Management	60	60
Substance Use Residential Treatment Facilities (pediatric[5])		
ASAM Level 3.1	60	60
ASAM Level 3.2 Withdrawal Management	60	60
ASAM Level 3.5	60	60
Psychiatric Inpatient Hospital Services[9]		
Hospital, Free Standing Psychiatric Unit	90	90
Hospital, Distinct Part Psychiatric Unit		
Mental Health Rehabilitation Services[9]		
Mental Health Rehabilitation Agency	30	15

Linkage Ratio Standards

Type	Linkage Ratio[8] (Provider: Enrollee)
Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC)	1:2,500
Adult Physician Extenders[6]	1:1,000
Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC)	1:2,500
Pediatric Physician Extenders[6]	1:1,000

Access and Timeliness Standards

Type of Visit/Admission/Appointment	Access/Timeliness Standard
Emergency care	24 hours, 7 days/week within 1 hour of request
Urgent non-emergency care	24 hours, 7 days/week within 24 hours of request,
Non-urgent sick primary care	72 hours
Non-urgent routine primary care	6 weeks
After hours, by phone	Answer by live person or call-back from a designated medical practitioner within 30 minutes
Ob/Gyn care for pregnant women	
1st Trimester	14 days
2nd Trimester	7 days
3rd Trimester	3 days
High risk pregnancy, any trimester	3 days
Family planning appointments	1 week

Specialist appointments	1 month
Scheduled appointments	Less than a 45 minute wait in office
Non-urgent routine behavioral health care	14 days
Urgent non-emergency behavioral health care	48 hours
Psychiatric inpatient hospital (emergency involuntary)	4 hours
Psychiatric inpatient hospital (involuntary)	24 hours
Psychiatric inpatient hospital (voluntary)	24 hours
ASAM Level ~~3.3~~, 3.5 & 3.7	10 business days
Residential withdrawal management	24 hours when medically necessary
Psychiatric Residential Treatment Facility (PRTF)	20 calendar days

Notes:

[1] For the purposes of assessing Network Adequacy, the MCO shall consider only those Providers who are actively providing services to enrollees, which shall be defined as (1) physical health providers who have submitted at least **one (1)** claim in an office setting within the prior **twelve (12)** calendar months; (2) behavioral health providers who have submitted at least **one (1)** claim within the prior **twelve (12)** calendar months; or (3) any providers who were newly contracted within the prior **twelve (12)** calendar months, regardless of claim submissions.

[2] The network ratio is a calculation of the MCO's Network Providers relative to the MCO's members.

[3] Unless otherwise specified in this Attachment, the Contractor must demonstrate that **ninety percent (90%)** of applicable members (adult or pediatric) have access to Network Providers for the type of service specified within the identified distance standard from the Enrollee's residence, based on a driving route versus a straight line calculation.

[4] For purposes of assessing Network Adequacy for OB/GYN specialty services, access standards are established based on female members age 18 and over. The Contractor shall not include OB/GYN providers in its assessment of Network Adequacy for Primary Care Services.

[5] For purposes of reporting Network Adequacy for physical health services, adult is defined as an Enrollee age 18 and over and pediatric is defined as an Enrollee under age 18 and for behavioral health services, adult is defined as an Enrollee age 21 and over and pediatric is defined as an Enrollee under age 21.

[6] In order to be included in the calculation, the Provider must work as a PCP at least 24 hours per week. The MCO may use physician extenders to meet PCP network ratios and distance standards. Physician extenders include nurse practitioners and physician assistants linked to a physician group who provide Primary Care Services. For calculation of the network ratio, each physician extender is counted with a factor of 0.5 while physician PCPs are counted with a factor of 1.0.

[7] For these specialties, the travel distance standards shall be applied separately to the Contractor's adult and pediatric member populations and to specialists serving the applicable age group(s).

[8] The linkage ratio is a calculation of the MCO's network provider to his/her patients who are Louisiana Medicaid managed care enrollees, regardless of MCO. The linkage ratios specified are applicable to providers who work as PCPs at least 24 hours per week.

[9] Network standards are applied across the provider types listed collectively within the identified distance standard from the Enrollee's residence, based on a driving route versus a straight line calculation from the applicable members (adult or pediatric) residences.

[10] Coverage of these dental services is provided by the Dental Benefit Program Manager (DBPM). Distance standards for these dental services are provided for the sole purpose of establishing a service area for transportation providers, to be used by the Contractor and its Transportation Broker.

LOUISIANA DEPARTMENT OF HEALTH

MCO Amendment G
Attachment G12 – Changes to Attachment G12, *Table of Monetary Penalties*

<table>
<tr><th>Item</th><th>Change From</th><th>Change To</th><th>Justification</th></tr>
<tr>
<td>1</td>
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<table>
<tr><th>Failed Deliverable or Deficiency</th><th>Penalty</th></tr>
<tr><td colspan="2">Services</td></tr>
<tr><td>Medical Transportation Services</td><td>Two thousand five hundred dollars ($2,500) per Calendar Day for each incident of failure to provide, or provide timely, a Non-Emergency Medical Transportation (NEMT) or Non-Emergency Ambulance Transportation (NEAT) service that is reported to LDH by an Enrollee, provider, or other third party.</td></tr>
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<tr><th>Failed Deliverable or Deficiency</th><th>Penalty</th></tr>
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<u>Twenty-five thousand dollars ($25,000) for each additional quarter, after the first quarter, that provider “no-shows” exceed 2% of NEMT trips scheduled to take place in that quarter.</u>

<u>Penalties for NEMT provider “no-shows” shall exclusively be assessed under this provision</u>.</td></tr>
</table>
</td>
<td>These revisions are necessary to address the issue of provider “no shows” for NEMT and to increase the penalty.</td>
</tr>
</table>

<table>
<tr><th>Item</th><th>Change From</th><th>Change To</th><th>Justification</th></tr>
<tr>
<td>2</td>
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<table>
<tr><th colspan="2">Provider Network, Support, and Reimbursement</th></tr>
<tr><th>Failed Deliverable or Deficiency</th><th>Penalty</th></tr>
<tr><td>Provider Network and Reimbursement</td><td>Ten thousand dollars ($10,000) per incident for failure:
To comply with Provider Network standards for ratio, distance, or timeliness of care;
To offer a Provider Agreement with mandatory contract provider types or to make three (3) documented attempts to contract with the provider; or
To pay for medically necessary services to an out-of-network provider.
One thousand dollars ($1,000) per Calendar Day for each Provider reimbursement rate that is not updated within the three (3) Calendar Day timeframe for National Average Drug Acquisition Cost (NADAC) rates.</td></tr>
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<tr><th colspan="2">Provider Network, Support, and Reimbursement</th></tr>
<tr><th>Failed Deliverable or Deficiency</th><th>Penalty</th></tr>
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To offer a Provider Agreement with mandatory contract provider types ~~or to make three (3) documented attempts to contract with the provider;~~ or
To pay for medically necessary services to an out-of-network provider.
One thousand dollars ($1,000) per Calendar Day for each Provider reimbursement rate that is not updated within the three (3) Calendar Day timeframe for National Average Drug Acquisition Cost (NADAC) rates.</td></tr>
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<td>This revision is necessary to comply with the new terms of the contract.</td>
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Medicaid Managed Care Organization Contract
Attachment G: Table of Monetary Penalties

See the *Contract Non-Compliance* section of Attachment A, *Model Contract* for additional information regarding Monetary Penalties. For any violation not explicitly described in the table below, LDH may impose a monetary penalty of up to $5,000 per occurrence per Calendar Day.

Failed Deliverable or Deficiency	Penalty
Contract Transition and Readiness	
Operational Start Date	Fifty thousand dollars ($50,000) per Calendar Day for each day beyond the Operational Start Date that the Contractor has not fully satisfied the Readiness Requirements, as determined by LDH.
Readiness Review	Five thousand ($5,000) per Calendar Day for each Readiness Review deliverable that is late, inaccurate, or incomplete.
Administration and Contract Management	
Employment of Key Personnel	One thousand dollars ($1,000) per Calendar Day per key personnel position for failure to have an individual serving in a full-time acting or permanent capacity in any key personnel position for more than two (2) consecutive Calendar Days, for each day the key personnel has not been appointed.
Additional Personnel Requirements	One thousand dollars ($1,000) per Calendar Day for any Contractor or Subcontractor personnel who performs work under the Contract without the appropriate license and or certification required by applicable State and Federal laws and/or regulations and the Contract. One thousand dollars ($1,000) per appropriate staff person per meeting or event for failure to provide subject appropriate staff member(s) to attend a meeting or event when required. One thousand dollars ($1,000) per appropriate staff person per meeting or event for failure to attend a meeting or event in person when required by the Contract or requested by LDH.

Failed Deliverable or Deficiency	Penalty
Conflict of Interest	Ten thousand dollars ($10,000) per occurrence plus an additional five thousand dollars ($5,000) per Calendar Day that the Contractor remains in violation of the conflict of interest requirements after notification of the violation by LDH.
Standing and Ad Hoc Reports	Two thousand dollars ($2,000) per Calendar Day for each report that is late, incorrect, incomplete, or does not meet Contract requirements. Five thousand dollars ($5,000): • Per Calendar Day for each report that is late for two (2) consecutive reporting periods or more than three (3) times within the calendar year; or • Per report returned to the Contractor for resubmission due to missing information or LDH-identified errors in data reported for two (2) consecutive reporting periods or more than three (3) times within the calendar year.
Requests for Information	One thousand dollars ($1,000) per Calendar Day that the Contractor or its Subcontractor fails to provide a timely and complete response to a request for information in accordance with the timelines established in the Contract or as otherwise specified by LDH.
Policies, Procedures, and Provider Manuals	Five thousand dollars ($5,000) for each new or materially amended policy, procedure, and provider manual that is implemented without prior approval from LDH, in accordance with the **MCO Manual**.
Services	
MCO Covered Services	The actual cost incurred by an Enrollee for obtaining an MCO Covered Service from another source, as authorized by LDH, due to failure of the Contractor to provide the service. Fifteen thousand dollars ($15,000) per Calendar Day for each incident of failure to provide an MCO Covered Service and LDH, in its sole discretion, determines that such failure results in actual harm to an Enrollee or places the Enrollee at risk of imminent harm.

Failed Deliverable or Deficiency	Penalty
Medical Transportation Services	~~Two thousand five hundred dollars ($2,500) per Calendar Day for each incident of failure to provide, or provide timely, a Non-Emergency Medical Transportation (NEMT) or Non-Emergency Ambulance Transportation (NEAT) service that is reported to LDH by an Enrollee, provider, or other third party.~~ **Ten thousand dollars ($10,000) for the first quarter that provider "no-shows" exceed 2% of Non-Emergency Medical Transportation (NEMT) trips scheduled to take place that quarter.** **Twenty-five thousand dollars ($25,000) for each additional quarter, after the first quarter, that provider "no-shows" exceed 2% of NEMT trips scheduled to take place in that quarter.** **Penalties for NEMT provider "no-shows" shall exclusively be assessed under this provision**.
Care Management	
Pre-Admission Screening and Resident Review (PASRR)	Five thousand dollars ($5,000) per month that less than ninety-five percent (95%) of PASRR Level II evaluations were submitted to OBH within four (4) Calendar Days of the receipt of referral.
Continuity of Care / Utilization Management	
Appropriate Care Alternatives for Residential Treatment	One thousand dollars ($1,000) for each denial of continuation of residential treatment for failure to meet medical necessity, when the Contractor did not provide the service at a lower level of care.
Appropriate Care Alternatives for Inpatient Hospital Service	One thousand dollars ($1,000) for each denial of continuation of higher-level services for failure to meet medical necessity, when the Contractor did not provide the service at a lower level of care.
Preferred Drug List (PDL)	One hundred thousand dollars ($100,000) per quarter in which the overall PDL compliance rate is less than ninety-two (92%) as described in the **MCO Manual**. One hundred thousand dollars ($100,000) per quarter in which the brand-over-generic PDL compliance rate is less than ninety-two percent (92%) as described in the **MCO Manual**.

Failed Deliverable or Deficiency	Penalty
Pharmacy Prior Authorization and Step Therapy	Ten thousand dollars ($10,000) per Calendar Day in which the application of Prior Authorization or step therapy criteria is more restrictive than FFS.
Crisis Response Services Prior Authorization	Five thousand dollars ($5,000.00) per calendar month in which the Contractor does not make at least ninety-five percent (95%) of the determinations for behavioral health crisis response services that require prior authorization within one (1) Calendar Day after obtaining appropriate documentation.
Provider Network, Support, and Reimbursement	
Provider Network and Reimbursement	Ten thousand dollars ($10,000) per incident for failure: • To comply with Provider Network standards for ratio, distance, or timeliness of care; • To offer a Provider Agreement with mandatory contract provider types ~~or to make three (3) documented attempts to contract with the provider~~; or • To pay for medically necessary services to an out-of-network provider. One thousand dollars ($1,000) per Calendar Day for each Provider reimbursement rate that is not updated within the three (3) Calendar Day timeframe for National Average Drug Acquisition Cost (NADAC) rates.
Provider Directory	Fifty thousand dollars ($50,000) per audit conducted by LDH wherein the Contractor's Provider Directory is found to have not maintained an accuracy rate of at least seventy-five percent (75%) per audit period or does not demonstrate a minimum accuracy rate of fifty percent (50%) in conjunction with a two (2) percentage point improvement from the prior audit period. One thousand dollars ($1,000) per Calendar Day for failure to correct inaccurate Provider Directory data within twenty-one (21) Calendar Days of notification by LDH.

Failed Deliverable or Deficiency	Penalty
Provider Relations	Fifteen thousand dollars ($15,000) per Calendar Day for failure to handle emergency provider issues twenty-four (24) hours per day seven (7) days per week. Fifteen thousand dollars ($15,000) per Calendar Day for failure to provide provider relations staff to handle non-routine Prior Authorization requests twenty-four (24) hours per day seven (7) days per week. Fifteen thousand dollars ($15,000) per Calendar Day for failure to furnish provider services functions from 7 a.m. to 7 p.m. Central Time, Monday through Friday to address non-emergency issues encountered by providers.
Provider Toll-Free Telephone Line	Twenty thousand dollars ($20,000) per Calendar Day for failure to operate a toll-free hotline that providers can access twenty-four (24) hours a day, seven (7) days a week. Five thousand dollars ($5,000) per percentage point for each standard that fails to meet the requirements for any applicable reporting period. Five thousand dollars ($5,000) for each thirty (30) second time increment, or portion thereof, by which the Contractor's daily average hold time exceeds the maximum acceptable hold time.
Payment for Hospital Services – Interim Payments	Up to 0.5% of the interim directed payment amount for each failure to provide an interim payment in full to an eligible hospital in accordance with the quarterly payment report within three (3) business days of receipt of the report from LDH.
Payment for Hospital Services – Reconciliation	Up to 0.5% of the net directed payment amount for each failure to perform the directed payment reconciliation in accordance with the instructions provided by LDH within the specified time period.
Enrollee Services, Marketing, Grievances	
Member ID Card	Five hundred dollars ($500.00) per incident of a justice-involved pre-release Enrollee's MCO Member ID card not arriving at the DOC facility specified on the lock-in file or supplied by LDH, or DOC headquarters in absence of a location code, within fifteen (15) Business Days from receipt of the file from LDH or the Enrollment Broker identifying the new Enrollee.

Failed Deliverable or Deficiency	Penalty
Enrollee Call Center	Twenty thousand dollars ($20,000) per Calendar Day for failure to operate a toll-free hotline that Enrollees can access twenty-four (24) hours a day, seven (7) days a week. Five thousand dollars ($5,000) for each thirty (30) second time increment, or portion thereof, by which the daily average hold time exceeds the maximum acceptable hold time. Five thousand dollars ($5,000) for each percentage point for each standard that fails to meet the requirements for any applicable reporting period.
Marketing/Steerage	Ten thousand dollars ($10,000) per marketing and education violation/incident outlined in the Contract. Amount of Capitation Payment attributed to Enrollees enrolled as a result of non-compliant marketing practices shall be deducted from the next monthly Capitation Payment. Five thousand dollars ($5,000) per Potential Enrollee that the Contractor or its Subcontractors steered to enroll with the Contractor.
Enrollee Grievances, Appeals, and State Fair Hearings	Twenty-five thousand dollars ($25,000): • Per occurrence that the Contractor created a barrier to timely due process as determined by LDH; • Per occurrence over ten percent (10%) within a Calendar Year that Enrollee appeals were reversed or otherwise resolved in favor of the Enrollee following a State Fair Hearing; or • Per occurrence that the Contractor failed to provide the medical services or requirements set forth in a final outcome of the administrative decision by LDH or the appeals decision of the State Fair Hearing.

Failed Deliverable or Deficiency	Penalty
24-Hour Behavioral Health Crisis line	Twenty thousand dollars ($20,000.00) per Calendar Day for failure to operate a behavioral health crisis line that Enrollees can access twenty-four (24) hours a day, seven (7) days a week. Five thousand dollars ($5,000.00) for each thirty (30)-second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold time. Five thousand dollars ($5,000.00) for each percentage point for each standard that fails to meet the requirements for any applicable reporting period.
Quality Management and Quality Improvement	
Quality Assessment and Performance Improvement Plan and Related Reports	Two thousand dollars ($2,000) per deliverable for each Calendar Day the QAPI plan, performance measure, and/or performance improvement project reports are late, inaccurate, or incomplete as outlined in this Contract and the **MCO Manual.**
Claims Management	
Prompt Pay	Five thousand dollars ($5,000) for the first month that the claims performance percentages by claim type fall below the performance standard. Twenty-five thousand dollars ($25,000) for each additional month that the claims performance percentages by claim type fall below the performance standards. One thousand dollars ($1,000) per claim if the Contractor fails to timely pay interest.
Claims Processing	One thousand dollars ($1,000) per claim that is not processed appropriately and results in an overpayment by the Contractor that is the subject of a Program Integrity audit finding.
Drug Utilization Review (DUR) Program	Two hundred fifty dollars ($250) per claim upon identification of DUR initiatives not or incorrectly implemented, plus five thousand dollars ($5,000) per day until programming is corrected and implemented.
Inappropriate Payment Denials, Delays, or Recoupments	The value of claims inappropriately denied, delayed, or recouped multiplied by a factor of 1.5.

Failed Deliverable or Deficiency	Penalty
Claim Adjustments	Managed care organizations shall be strictly prohibited from amending, modifying, or changing in any manner a claim submitted by a healthcare provider or adjusting, down-coding, or paying a claim at a lower level of service than what was submitted by the healthcare provider. Twenty-five thousand dollar ($25,000) minimum penalty per violation. One hundred thousand dollar ($100,000) minimum penalty for multiple violations.
Encounter Data	Ten thousand dollars ($10,000) per Calendar Day that the monthly encounter data has not been received in the format and per the specifications outlined in the Contract and **MCO System Companion Guide**. Twenty-five thousand dollars ($25,000) per occurrence in each bimonthly reconciliation in which LDH or its designee determines that the Contractor or its subcontracted vendor(s), individually or in aggregate, failed to submit complete encounter data within the applicable error threshold plus an additional ten thousand dollars ($10,000) for each additional percentage point or fraction thereof. Five thousand dollars ($5,000) for the first month for failure meet the encounter processing performance standards for reported repairable errors. For each additional month, the penalty increases to twenty-five thousand dollars ($25,000) per month. *Note: At the discretion of LDH, the penalties specified above may not apply for encounter data for the first month after the Operational Start Date, new required services are added, or major system changes are implemented to permit time for development and implementation of a system for exchanging data and training of staff and Health Care Providers.*
Claims Summary Report	One thousand dollars ($1,000) per Calendar Day that the claims summary report is late, inaccurate, or incomplete.

Failed Deliverable or Deficiency	Penalty
Pharmacy Encounter Data	Ten thousand dollars ($10,000) per Calendar Day that the pharmacy encounter claims file and/or the disputed encounter response file have not been submitted to LDH in the format and per the specifications outlined in the Contract and **MCO Manual**. In addition to the above, a quarterly offset equal to the value of the rebate assessed on the disputed encounters may be deducted from the Contractor's Capitation Payment.
Systems and Technical Requirements	
Provider Registry and PCP Linkages	Two thousand dollars ($2,000): • Per Calendar Day that the Contractor fails to submit a complete electronic weekly Provider Registry file in the format described in the **MCO System Companion Guide**; • Per submission of the electronic Provider Registry file in which one or more non-contracted or non-credentialed providers remain listed as contracted; and • Per Calendar Day that the Contractor fails to submit a complete electronic weekly Primary Care Provider linkage file as described in the **MCO System Companion Guide**.
Information Systems Availability	Fifteen thousand dollars ($15,000) per Calendar Day per core eligibility/enrollment and claims processing system that is not restored within seventy-two (72) hours of declared major failure or disaster. One thousand dollars ($1,000) per hour for failure to restore system functions within the Contractor's span of control beyond the time limits provided in the Contract.
Medical Loss Ratio	
Medical Loss Ratio	Twenty-five thousand dollars ($25,000) per finding that is identified by LDH or its designee in two (2) consecutive examinations of the Contractor's Medical Loss Ratio report.

Failed Deliverable or Deficiency	Penalty
Third Party Liability	
Third Party Liability	Penalties equal to the amount that could have been recovered for failure to demonstrate that reasonable effort has been made to seek, collect and/or report TPL and recoveries. Penalties no less than three (3) times the amount that could have been cost avoided for failure to actively engage in cost avoidance activities. Penalties equal to the amount that could have been recovered for failure to actively seek reimbursement in accident/trauma related cases when claims for an Enrollees in the aggregate equal or exceed five hundred dollars ($500).
Turnover Requirements	
Turnover Plan	Ten thousand dollars ($10,000) per Calendar Day the Turnover Plan is late, inaccurate, or incomplete.
Other Terms and Conditions	
Continuity of Operations Plan	Ten thousand dollars ($10,000) per Calendar Day the Continuity of Operations Plan is late, inaccurate, or incomplete, up to one hundred thousand dollars ($100,000). An additional two hundred thousand dollars ($200,000) for failure to submit a complete and accurate update of the plan at least thirty (30) days prior to the start of the Atlantic hurricane season, which begins June 1st, or a certification that the plan has not changed since the last LDH approval of the plan.
Homeland Security Considerations	Fifty thousand dollars ($50,000) per occurrence that the Contractor has hired an individual without a work visa, approved by the U.S. Department of Homeland Security, to perform any services under this Contract.