REQUEST FOR PROPOSALS

for

Pharmacy Benefit Management Services

for Louisiana Medicaid Managed Care Organizations

RFP #:3000018331

Proposal Due Date/Time: Thursday, March 10, 2022,

4:00 PM Central Time

State of Louisiana

Louisiana Department of Health

Bureau of Health Services Financing

Friday, January 14, 2022

Table of Contents

1 ADMINISTRATIVE AND GENERAL INFORMATION

1.1 Purpose

The purpose of this Request for Proposal (RFP) is to obtain competitive proposals from qualified and experienced organizations interested in serving as the single Pharmacy Benefit Manager (PBM) for Managed Care Program. The Contractor shall provide one PBM solution that interfaces with each Managed Care Organization (MCO). The Contractor shall process Drug Claims equally and uniformly for all MCOs to avoid duplication of effort and reduce administrative overhead.

This RFP solicits proposals, details proposal requirements, defines minimum service requirements, and outlines the State's process for evaluating proposals and selecting an entity to serve as the single PBM for the MCOs. The Louisiana Department of Health (the Department or LDH) seeks to contract for the needed services and to give all qualified businesses, including those that are owned by minorities, women, persons with disabilities, and small business enterprises, the opportunity to do business with the State.

The Contractor shall ensure the following business goals are met:

- Ensure business outcomes are delivered.
- Strive to improve health outcomes.
- Advance the efficiency and economy of the Louisiana Medicaid Program's pharmacy benefit.

The successful Proposer shall contract with each of the MCOs to implement the Louisiana Medicaid Program's pharmacy benefit as directed by the Louisiana Department of Health (LDH), without exception. The successful Proposer shall have a zero dollar contract with LDH to establish a basis for contractual terms. LDH shall specify, and the Contractor shall follow, without exception, drug coverage, edits, utilization management strategies, and all other requirements for administration of the pharmacy benefit.

As payment-in-full for PBM services provided, the Contractor shall receive a transaction fee for each paid Drug Claim from each MCO in accordance with an LDH-approved methodology. The Contractor shall also receive payments for pharmacy reimbursement directly from the MCOs on a weekly basis. The Contractor shall provide a transparent pass-through model of reimbursement. In accordance with La. R.S. 46:450.7, the Contractor is prohibited from facilitating spread pricing. The Contractor is prohibited from applying retrospective claw backs, true-ups or effective rates without written approval by LDH.

This RFP is designed to provide interested vendors with sufficient information to submit proposals meeting minimum requirements but is not intended to limit a proposal's content or exclude any relevant or essential information. Proposers are encouraged to expand upon the specifications to evidence service capability and features that bring added value and innovation to LDH.

LDH's ideal Contractor shall be an active partner and continuously collaborate with LDH and the MCOs to enhance the management of the pharmacy benefit and improve Beneficiary outcomes.

1.2 Background

The Louisiana Department of Health (LDH) is the single state agency designated to administer or supervise the administration of the State's Medicaid and the Louisiana Children's Health Insurance Program (LaCHIP) in accordance with Federal regulations. The Bureau of Health Services Financing (BHSF) is the agency within LDH that is responsible for administering the Louisiana Medicaid Program.

The Managed Care Program, implemented in 2012, is designed to improve health outcomes and contain costs through coordination of acute care, specialized behavioral health, and medical transportation services for Enrollees. In 2016, Louisiana implemented the expansion of Louisiana Medicaid Program eligibility under the Patient Protection and Affordable Care Act (ACA).

In Louisiana, over 1.8 million Louisiana residents receive health care coverage through the Louisiana Medicaid Program and LaCHIP, of which approximately 1.7 million are enrolled as a member in an MCO.

LDH currently contracts with five (5) MCOs. Each MCO currently contracts with a separate PBM for its Enrollees. In State Fiscal Year (SFY) 2020, the MCOs had annual total Drug Claim expenditures in excess of $1.7 billion for approximately 19 million Drug Claims.

1.3 Goals and Objectives

LDH desires to improve management and administration of the pharmacy benefit for Beneficiaries. A single MCO PBM will assist in attaining these goals by providing LDH with increased financial accountability, streamlining processes, and ensuring alignment with clinical and policy goals, while also improving transparency.

1.4 Term of Contract

The term of any contract resulting from this RFP shall begin on or near the date approximated in the Schedule of Events. LDH shall have the right to contract for up to thirty-six (36) months with the concurrence of the Contractor and all appropriate approvals. The Department may also exercise an option to extend for up to twenty-four (24) additional months at the same rates, terms and conditions of the initial contract term.

Notwithstanding the foregoing, prior approval by the Joint Legislative Committee on the Budget (JLCB) or other approval authorized by law shall be obtained prior to the extension of the contract beyond the initial thirty-six (36) month term. Such 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 3-year term. The total contract term, with extensions, shall not exceed five (5) years. The continuation of the Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract.

No contract/amendment shall be valid, nor shall the LDH be bound by the contract/amendment, until it has first been executed by the Secretary of LDH, or his designee, and approved in writing by OSP.

1.5 Definitions and Acronyms

1.5.1 Definitions

TERM	DEFINITION
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 before speaking to a live person.
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.
Adjudicate	To deny or pay a Drug Claim in accordance with Federal and State laws, rules, regulations, policies, procedures, manuals, and guidance and the State Plan.
Adverse Benefit Determination	Any of the following: • The denial or limited authorization of a requested service, including, but not limited to, determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole or in part, of payment for a service. • The failure to provide services in a Timely manner, as defined by the State. • The failure of an MCO to act within the timeframes provided in 42 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.
Appeal	A request for a review of an Adverse Benefit Determination.
Beneficiary	An individual who has been determined eligible, pursuant to Federal and State laws, rules, regulations, policies, procedures, and manuals and the State Plan, to receive medical care, goods, or services through the Louisiana Medicaid Program.
Blackout Period	A specified period of time during a competitive sealed procurement process in which any Proposer, or its agent or representative, is prohibited from communicating with any State employee or contractor of the State involved in any

TERM	DEFINITION
	step in the procurement process about the affected procurement.
Bureau of Health Services Financing (BHSF)	The organizational unit within the Louisiana Department of Health responsible for day-to-day administrative operations of the Louisiana Medicaid Program.
Business Day	Monday, Tuesday, Wednesday, Thursday, and Friday, excluding State-designated holidays.
Business Hours	8:00 a.m. to 5:00 p.m. Central Time on Business Days.
Calendar Day	All seven (7) days of the week. Unless otherwise specified, the term "days" in this RFP refers to Calendar Days.
Can	Denotes an advisory or permissible action.
Centers for Medicare and Medicaid Services (CMS)	The organizational unit within the United States Department of Health and 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.
Continuity of Operations Plan	A plan that provides for a quick and smooth restoration of all Contractor functions after a disruptive event. The Continuity of Operations Plan includes business impact analysis, development, testing, awareness, training, and maintenance. This is a day-to-day plan.
Contract	The written agreement between the Louisiana Department of Health (LDH) and the Contractor, which is comprised of the terms and conditions set forth in the CF-1, any attachments and/or exhibits incorporated therein, and any amendments thereof; the RFP and any addenda issued thereto; the Contractor's proposal, and any appendices, attachments, and exhibits thereto or incorporated therein by reference.
Contract Start Date	The effective date of the Contract, as set forth in the LDH Standard Contract Form (Attachment II).
Contractor	The entity that enters into any contract resulting from this Request for Proposals (RFP).
Defect	An error or a bug or a failure of the system, solution, or enhancement to perform as contracted or to meet specifications.
Department	The Louisiana Department of Health.
Discussions	A formal, structured means of conducting written or oral communications/presentations with Proposers.
Drug Claim	A claim from a Network Provider for payment of a PBM Covered Service.

TERM	DEFINITION
Dual Eligible	A Beneficiary who is enrolled in both the Louisiana Medicaid Program and Medicare.
Enhancement	A product functionality change or upgrade that increases software or hardware capabilities beyond original specifications.
Enrollee	A Beneficiary who is currently enrolled in an MCO.
Fee-for-Service (FFS)	A method of Provider reimbursement based on payments for specific services rendered outside the Managed Care Program.
Fiscal Intermediary (FI)	LDH's contractor responsible for an array of support services including Medicaid Management Information System (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.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes Fraud under applicable Federal or State law. Fraud may include, but is not limited to, deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or requesting payment for services that were never delivered or received.
Grievance	An expression of dissatisfaction about any matter other than an Adverse Benefit Determination.
Labeler	The unique five (5) digit code assigned to any entity that manufactures, repacks, or distributes a drug product; the first five (5) digits of a National Drug Code (NDC).
Local Pharmacy	Any pharmacy domiciled in at least one parish that contracts with the Contractor in its own name or through a Pharmacy Services Administrative Organization (PSAO) and not under the authority of a group purchasing organization; and has fewer than ten retail outlets under its corporate umbrella.
Louisiana Children's Health Insurance Program (LaCHIP)	The State'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.

TERM	DEFINITION
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 Medicaid Program	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)	The private entities contracted with LDH to provide covered benefits and services to Enrollees in exchange for a monthly prepaid capitated amount per Enrollee.
Managed Care Program	A managed care delivery system wherein health care services covered under the Louisiana Medicaid Program are provided through MCOs.
Material Change	A change that 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: • A termination or non-renewal of a Non-Local Pharmacy within the Network; • A change to one (1) of the Subcontractors; • 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; • Other adverse changes to the composition of the Network which result in the Contractor's inability to meet the network adequacy and Timely access to care standards of the Contract or which impair or deny an Enrollee's adequate access to Network Providers such as capping of patient loads by Network Providers impacting availability of qualified specialists in a region.
Maximum Allowable Cost (MAC)	The maximum amount allowed that will be paid for a specific drug and strength for a PBM Covered Service.
May	Denotes an advisory or permissible action.
MCO Network	Providers who have an agreement with the MCO, or a Provider Agreement with the Contractor, to provide services under the Louisiana Medicaid Program to the MCO's Enrollees.

TERM	DEFINITION
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 Providers for serving covered individuals.
Medicaid Exclusion File	The quarterly file produced by the Health Resources and Services Administration that identifies Public Health Services providers that carve Beneficiaries into their 340B programs.
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.
Medicare	The Federal medical assistance program authorized in 1965 by Title XVIII of the Social Security Act, to address medical needs for certain U.S. citizens sixty-five (65) years of age and older and some people with disabilities under the age of sixty-five (65).
Must	Denotes a mandatory action.
National Drug Code (NDC)	The identifying drug number maintained by the Food and Drug Administration. For the purposes of this RFP, the complete eleven (11) digit NDC number will be used including labeler code (which is assigned by the FDA and identifies the manufacturer), product code (which identifies the specific product or formulation), and package size code.
Network	The collective group of Providers who have entered into Provider Agreements with the Contractor for the delivery of PBM Covered Services.
Network Provider	Any Provider, group of Providers, or entity that has a Provider Agreement with the Contractor and receives Louisiana Medicaid Program funding directly or indirectly to render PBM Covered Services.
Non-Local Pharmacy	A pharmacy that does not meet the definition of a Local Pharmacy.
Original	Denotes must be signed in ink.
PBM Covered Services	Drugs and supplies that are payable as an outpatient retail pharmacy claim under the Louisiana Medicaid program.
Pharmaceutical and Therapeutics (P&T) Committee	Responsible for developing and maintaining the Preferred Drug List (PDL) in conjunction with the Prior Authorization process relating to prescribed drugs covered under the Louisiana Medicaid Program.
Preferred Drug List (PDL)	The list of medications adopted by the Louisiana Medicaid Program, in consultation with the P&T Committee, that are covered without Prior Authorization.

TERM	DEFINITION
Prescriber	An individual Provider who is authorized by their governing board and law to have prescriptive authority and has executed an agreement with the MCO to provide services under the Louisiana Medicaid Program to the MCO's Enrollees.
Professional Dispensing Fee	The professional fee that: (1) Is incurred at the point of sale or service and pays for the costs in excess of the ingredient cost of a covered outpatient drug each time a covered outpatient drug is dispensed. (2) Includes only pharmacy costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to an Enrollee. Pharmacy costs include, but are not limited to, reasonable costs associated with a pharmacist's time in checking the computer for information about an Enrollee's coverage, performing drug utilization review and preferred drug list review activities, measurement or mixing of the covered outpatient drug, filing the container, Enrollee counseling, physically providing the completed prescription to the Enrollee, delivery, special packaging, and overhead associated with maintaining the facility and equipment necessary to operate the pharmacy. (3) Does not include administrative costs incurred by the Contractor in the provision of PBM Covered Services including system costs for interfacing with Network Providers.
Prospective Drug Utilization Review	Clinical screening occurring every time a pharmacist processes a prescription prior to dispensing to assure safe and medically necessary drug utilization.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services.
Provider Agreement	An agreement between the Contractor and a Provider for the delivery of PBM Covered Services to Enrollees.
Provider Fee	The fee paid by pharmacies to LDH for each outpatient prescription, in accordance with La. R.S. 46:2625.
Prior Authorization (PA)	A Prescriber-initiated request for prior approval on a selected number of drugs (non-preferred) within specific therapeutic classes.
Proposer	A firm or individual who responds to this RFP.
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

TERM	DEFINITION
	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.
Shall	Denotes a mandatory action.
Should	Denotes a desirable action.
Specialty Drug	A prescription drug that meets any three (3) or more of the following criteria: • The drug cannot be routinely dispensed at the 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 Food and Drug Administration, and/or drugs that require physical facilities not typically found in a retail community pharmacy, such as a ventilation hood for preparation. • The drug is used to treat complex, chronic, or rare medical conditions: o That can be progressive; o That can be debilitating or fatal if left untreated or undertreated; or o For which there is no known cure. • The drug requires special handling, storage, and/or has distribution and/or inventory limitations. • The drug has a complex dosing regimen or requires specialized administration. • Any drug that is considered to have limited distribution by the Food and Drug Administration. • The drug requires: o Complex and extended patient education or counseling; o Intensive monitoring; or o Clinical oversight; and o Has significant side effects and/or risk profile.
Specialty Pharmacy	A State-licensed pharmacy that provides medications for people with serious health conditions requiring complex therapies.
Spread Pricing	Any amount charged or claimed by the Contractor to an MCO that is in excess of the net amount, after all discounts,

TERM	DEFINITION
	chargebacks or other price concessions, paid to the dispensing pharmacy, including the ingredient cost, Provider Fee and Professional Dispensing Fee.
State	The State of Louisiana and its departments, agencies (including the Louisiana Department of Health), boards, and commissions as well as their officers, agents, servants, employees, and volunteers.
State Fair Hearing	The process set forth in 42 CFR Part 431, Subpart E.
State Fiscal Year (SFY)	July 1st through June 30th each year.
State Plan	Refers to the Louisiana Medicaid State Plan and the LaCHIP State Plan.
Steering	Requiring or encouraging Beneficiaries to utilize certain Providers and away from others.
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 PBM Covered Services to Enrollees. A Network Provider is not a Subcontractor by virtue of the Provider Agreement with the Contractor.
Third Party Liability (TPL)	The legal obligation of a third party to pay all or part of the expenditures for medical assistance furnished to a Beneficiary under the Louisiana Medicaid Program.
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/or the Contract.
Transaction Fee	The fee the Contractor will be reimbursed for each paid Drug Claim that will be payment-in-full for all services provided under the Contract. Transaction Fee does not include reimbursement to Providers of the Professional Dispensing Fee, Ingredient Cost and any applicable fees, which must be passed-through from MCO to Contractor to Providers using a transparent pass-through method of payment.
Using Agency	The Louisiana Department of Health.
Usual and Customary (U&C) Charge	The price the Provider most frequently charges the general public for the same drug unless otherwise defined in the State Plan in effect on the date of service (DOS).
Weekly	The entire seven-day week, Monday through Sunday.
Will	Denotes a mandatory action.

1.5.2 Acronyms

ACRONYM	DEFINITION
ACA	Affordable Care Act
BAFO	Best and Final Offer

ACRONYM	DEFINITION
BCP	Business Continuity Plan
BHSF	Bureau of Health Services Financing
BIA	Business Impact Analysis
BIN	Bank Identification Number
CEO	Chief Executive Officer
CHC	Certified in Healthcare Compliance
CHC-F	Certified in Healthcare Compliance - Fellowship
CHIP	Children's Health Insurance Program
CHPC	Certified in Healthcare Privacy Compliance
CHRC	Certified in Healthcare Research Compliance
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
COO	Chief Operational Officer
CSC	Customer Service Center
DME	Durable Medical Equipment
DOA	Division of Administration
DOS	Date of Service
DRA	Deficit Reduction Act
DRP	Disaster Recovery Plan
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
FDA	Food and Drug Administration
FFS	Fee for Service
FI	Fiscal Intermediary
FWA	Fraud, Waste, and Abuse
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability
HL7	Health Level Seven International
HRSA	Health Resources and Services Administration
ICD	Internal Classification of Disease
ICN	Internal Control Number
IVR	Interactive Voice Response
JLCB	Joint Legislative Committee on the Budget
LDH	Louisiana Department of Health
LED	Louisiana Department of Economic Development
LEP	Limited English proficiency
MAC	Maximum Allowable Cost
MCO	Managed Care Organization
MEF	Medicaid Exclusion File
MFCU	Medicaid Fraud Control Unit
MME	Morphine Milligram Equivalents

ACRONYM	DEFINITION
MMIS	Medicaid Management Information System
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NPI	National Provider Identifier
OBRA 90	Omnibus Budget Reconciliation Act of 1990
OPAP	Other Payer Amount Paid
OSP	Office of State Procurement
OTS	Office of Technology Services
P&T	Pharmaceutical and Therapeutics Committee
PA	Prior Authorization
PBM	Pharmacy Benefit Manager
PCN	Processor Control Number
PDL	Preferred Drug List
PHI	Protected Health Information
PII	Personally Identifiable Information
PMP	Project Management Plan
POS	Point-of-Sale
ProDUR	Prospective Drug Utilization Review
PPS	Professional Pharmacy Services
PSAO	Pharmacy Services Administrative Organization
RA	Remittance Advice
RCA	Root Cause Analysis
RFP	Request for Proposal
SAS	Statistical Analysis System
SFY	State Fiscal Year
SSA	Social Security Act
SSI	State Sensitive Information
TCS	Transactions and Code Sets
TPL	Third Party Liability
TTY/TDY	Teletypewriter/Telecommunications Device for the Deaf
UM	Utilization Management

1.6 Schedule of Events

EVENT	DATE
RFP advertised in newspapers and posted to LaPac	Friday, January 14, 2022
Deadline for receipt of written inquiries from Proposers	Monday, January 31, 2022 3:00 PM Central Time
Deadline for LDH to answer written inquiries	Tuesday, February 22, 2022
Deadline for receipt of Proposals	Thursday, March 10, 2022 3:00 PM Central Time

ALL PROPOSALS SHALL REMAIN SEALED UNTIL AFTER THE DEADLINE FOR RECEIPT OF PROPOSALS	
Notice of Intent to award announcement, and 14-day protest period begins, on or about	Thursday, April 14, 2022
Contract execution, on or about	Monday, May 2, 2022
Operational start date, on or about	Friday, July 1, 2022

NOTE: The State of Louisiana reserves the right to revise this schedule. Revisions, if any, before the Proposal Submission Deadline will be formalized by the issuance of an addendum to the RFP.

1.7 Qualification for Proposer

The Proposer shall meet all standards and must comply with all mandatory proposal submission requirements in this section.

1.7.1 Mandatory Qualifications:

Proposers must meet or exceed the following qualifications prior to the deadline for receipt of proposals. In order to be considered for award, the Proposer must demonstrate that it has met the following mandatory requirements:

- Have a minimum of five (5) full years of experience as a PBM for a state Medicaid program (fee for service (FFS) or MCO) prior to the deadline for receipt of proposals.
- Have, within the last thirty-six (36) months prior to the deadline for receipt of proposals, been engaged in a contract or awarded a new contract as a PBM with a population equal to or greater than 1.5 million Beneficiaries.
- Have its principal place of business be located inside the continental United States.
- Provide copies of its latest three (3) years of audited financial statements.

1.7.2 Desirable Qualifications:

It is desirable that Proposers should meet the following qualifications prior to the deadline for receipt of proposals:

- Have the ability to accept, price, and process physician-administered Drug Claims, applying the same edits and utilization management (UM) criteria as those applied to a National Council for Prescription Drug Programs (NCPDP) Drug Claim, and/or additional edits as specified by LDH.
- Have the ability to enhance Enrollee access and convenience (e.g., mobile app access).
- Have the capability to, as directed and/or approved by LDH, implement a suite of technical Prescriber tools/electronic prescribing systems, or health information exchanges to maintain and support the PDL, prior authorizations (PAs), and coverage details of the Louisiana Medicaid Program.

1.8 Proposal Response Format

Proposers should respond, item by item, to each section under 1.8 Proposal Response Format. There is no intent to limit the content of the proposals, and Proposers may include any additional information deemed pertinent. Emphasis should be straightforward and concise statements,

summarizing the Proposer's ability to satisfy the requirements of the RFP and outlining the exceptional qualities they bring to the proposal.

Proposals should include information that will assist the Department in determining the level of quality and timeliness that may be expected. The Department shall determine, at its sole discretion, whether or not the RFP provisions have been reasonably met. The proposal should describe the background and capabilities of the Proposer, give details on how the services will be provided, and shall include a breakdown of proposed costs. Work samples may be included as part of the proposal.

Proposals should address how the Proposer intends to assume complete responsibility for timely performance of all contractual responsibilities in accordance with Federal and State laws, rules, regulations, policies, procedures, and manuals and the State Plan.

Proposals submitted for consideration should follow the format and order of presentation described below:

1.8.1 Cover Letter

A cover letter should be submitted on the Proposer's official business letterhead explaining the intent of the Proposer. Cover letter should contain the following information:

- Summary information about the Proposer's organization.
- Location of Central Administrative Office with Full Time Personnel, including the address for all office locations with full time personnel.
- Name and address of principal officer.
- Name and address for purpose of issuing checks and/or drafts.
- For corporations, a statement listing name(s) and address(es) of principal owners who hold five percent (5%) interest or more in the corporation.
- If out-of-State Proposer, give name and address of local representative; if none, so state.
- If the Proposer was engaged by LDH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; (if none, so state).
- Proposer's state and Federal tax identification numbers.

The cover letter should include a positive statement of compliance with the contract terms defined herein. If the Proposer cannot comply with any of the contract terms, an explanation of each exception should be supplied. The Proposer should indicate the specific section and language in the RFP and submit exceptions or exact contract modifications that it may seek.

1.8.2 Table of Contents

The proposal should contain a table of contents, and each section in hard copy submissions should be separated by a tabbed page that includes headings and numbering to match the corresponding section of the RFP.

1.8.3 Executive Summary

This section serves to introduce the scope of the proposal. It shall include administrative information including Proposer contact name and phone number, and the stipulation that the proposal is valid for a time period of at least ninety (90) Calendar Days from the date of submission. This section should also include a summary of the Proposer's qualifications and ability to meet the State agency's overall requirements in the timeframes set by the agency.

1.8.4 Company Background and Experience

The Proposer should give a brief description of their organization or corporate entity including brief history, corporate or organization structure, number of years in business. The Proposer shall include copies of its latest three (3) years of audited financial statements. The proposal should indicate the Proposer's firm has a record of prior successful experience in the implementation of the services sought through this RFP. Proposers should include statements specifying the extent of responsibility on prior projects and a description of the projects' scope and similarity to the scope of services outlined in this RFP. All experience under this section should be in sufficient detail to allow an adequate evaluation by the Department. The Proposer should have, within the last thirty-six (36) months, implemented a similar type of project. Proposers should identify at least two customer references for projects implemented in the last twenty-four (24) months. References shall include the name, email address and telephone number of each contact person.

The Proposer shall provide a brief statement if any of the following has occurred: Within the last ten (10) years, Proposer's Pharmacy Benefits Manager contract was (1) terminated or not renewed for non-performance or poor performance; and/or (2) terminated on a voluntary basis prior to the contract end date. The Proposer must provide the name and contact information of the lead program manager of the contracting entity.

The Proposer shall disclose all financial, legal, contractual, and other business interests of the Proposer and any Subcontractor, affiliate, partner, parent, subsidiary, or other similar entity related to the activities detailed in the Scope of Work. In this section, a statement of the Proposer's involvement in litigation that could affect this work should be included. If no such litigation exists, the Proposer should so state.

Proposers should clearly describe their ability to meet or exceed the qualifications described in the Mandatory Qualifications for Proposer section.

Proposers should clearly describe their ability to meet or exceed the desired qualifications described in the Desirable Qualifications for Proposer section.

1.8.5 Approach and Methodology

Proposals should define the Proposer's functional approach in providing services and identify the tasks necessary to meet the RFP requirements of the provision of services, as outlined in *Section 2. Scope of Work*. Proposals should include enough information to satisfy evaluators that the Proposer has the appropriate experience, knowledge and qualifications to perform the scope of services as described herein. Proposers should respond to all requested areas.

1.8.6 Administrative Data

This section should:

- State Proposer's knowledge and understanding of the needs and objectives of LDH Pharmacy and the MCOs as related to the scope of this RFP.
- Provide a written explanation of the Proposer's organizational structures of both operations and program administration, and a description of how the components communicate and work together in both an administrative and functional capacity from the top down.
- Contain a brief summary setting out the Proposer's management philosophy including, but not limited to, the role of Quality Control, Professional Practices, Supervision, Distribution of Work and Communication System.

1.8.7 Work Plan/Project Execution

The Proposer should articulate an understanding of, and ability to, effectively implement services as identified in Section 2. Scope of Work. In this section, the Proposer should state the approach it intends to use in achieving each objective of the scope as outlined, including a project work plan and schedule for implementation.

The Proposer should:

- Provide a written explanation of how the operations and program administration components of the Proposer's organizational structures will support service implementation. Individual components should include plans for supervision, training, technical assistance, as well as collaboration as appropriate.
- Demonstrate an ability to hire staff with the necessary experience and skill set that will enable them to effectively meet the needs of Enrollees.
- Demonstrate an understanding of, and ability to implement, the various types of organizational strategies to be integrated within the day-to-day operations.
- Demonstrate knowledge of services to be provided and effective strategies to achieve objectives and effective service delivery.
- Describe approach and strategy for project oversight and management.
- Articulate the need for, and the ability to implement, a plan for continuous quality improvement. This includes (but is not limited to) reviewing the quality of services provided and staff productivity.
- Demonstrate an understanding of and ability to implement data collection, as needed.
- Demonstrate an understanding of fiduciary duty, and knowledge of all applicable Louisiana legislative requirements.
- Define its functional approach in providing the services.
- Define its functional approach in identifying the tasks necessary to meet requirements.
- Describe the approach to Project Management and Quality Assurance.
- Provide a proposed Project Work Plan that reflects the approach and Agile project management methodology, tasks and services to be performed, deliverables, timetables, and staffing.

- Provide approach and detail the methodology/formula in defining the applicable transaction fee.
- Explain processes to implement in order to complete all tasks and phases of the project in a timely manner, as outlined within *Section 2. Scope of Work*.
- Articulate the ability to develop and implement a Continuity of Operations Plan (COOP) in the event of an emergency.
- Refer to specific documents and reports that can be produced as a result of completing tasks, to achieve the requested deliverables.
- Identify all assumptions and constraints for work plan tasks.
- Discuss what flexibility exists within the work plan to address unanticipated problems which might develop during the contract period.
- Document procedures to protect the confidentiality of records in LDH databases, including records in databases that may be transmitted electronically via e-mail or the Internet.
- Clearly outline the solution's technical approach as it relates to a service-oriented architecture. Details should include a description of capability and potential strategy for integration with future Department enterprise components as they are established, specifically making use of an Enterprise Service Bus (ESB) for managing touch points with other systems, integration with a Master Data Management Solution (MDMS) and flexibility to utilize a single Identity and Access Management Solution (IAMS). The Proposer shall clearly identify any systems or portions of systems outlined in the proposal, which are considered proprietary in nature.

1.8.8 Detailed Scope Response

Describe its proposed approach to meeting each of the requirements below. The narrative response should demonstrate clear understanding of all the requirements in each category. Any requirement not clearly addressed in the response may negatively affect the Proposer's scoring. The Proposer should respond, at a minimum, to the following sections:

- Coordination with the MCOs: Describe the proposed approach to meet the requirements for coordination with the MCOs included in *Section 2.1.3*, including detailed transition activities.
- Pharmacy and Prescriber network management: Describe each network separately, including but not limited to, compliance with Federal and State regulations, as well as addressing each subsection.
- Drug Claims/System Requirements: Describe the approach to, including but not limited to, processing Drug Claims consistently across all MCOs, compliance with Federal and State regulations, LDH policy, programming flexibility, compound drug policy and process for benefit changes.
- Covered Drug List (CDL) / Preferred Drug List (Single PDL): Describe in detail how the Proposer will operationalize and maintain compliance with the Single PDL and prior authorization requirements.
- Behavioral Health Policies and Procedures: Describe the proposed approach to meet the requirements in *Section 2.1.11.*

- Specialty drugs and pharmacies: Describe the proposed approach to meet the requirements in *Section 2.1.12*.
- Drug Utilization Review (DUR): Describe the operations for the prospective component of DUR including compliance with Federal regulations and coordination with the LDH DUR Board, LDH pharmacy staff and the MCOs.
- Provider and Enrollee support: Describe approach to provide appropriate staff for Provider and Enrollee inquiries and compliance with LDH and MCO requirements.
- Oversight and monitoring: Describe the proposed approach to meet the requirements in *Section 2.1.15*.
- State and Federal Mandate Compliance: Describe the proposed approach to meet the requirements in *Section 2.1.17*.
- Audit: Describe approach to provide an audit program (*Section 2.1.18*).
- Security and privacy: Describe the proposed approach to meet the requirements in *Section 2.1.23*.
- Reporting and quality assurance: Describe the ability to provide standardized and ad hoc reporting.
- Emergencies and disaster planning: Describe the proposed approach to meet the requirements in *Section 2.1.25*.
- Continuity of Operations Plan (COOP): Describe the proposed approach to meet the requirements in *Section 2.1.26*.

1.8.9 Innovative Concepts and Value-Added Services

LDH is interested in exploring value added services the Proposer may offer. The Proposer is encouraged to work with LDH as well as the MCOs to identify and propose value-added services that may apply to MCO-specific populations. LDH may approve the provision of value-added services offered by the Proposer throughout the term of the Contract. The provision of value-added services shall be subject to the explicit written approval of LDH.

The Proposer may present innovative concepts for consideration. The Proposer may present value-added benefits for LDH approval.

1.8.10 Proposed Staff Qualifications

Proposers should state job responsibilities, workload and lines of supervision for both Key Personnel and General Staff. An organizational chart identifying individuals and their job titles and major job duties should be included. The organizational chart should show lines of responsibility and authority.

Job descriptions, including the percentage of time allocated to the project and the number of personnel should be included indicating minimum education, training, experience, special skills and other qualifications for each staff position as well as specific job duties identified in the proposal. Job descriptions should indicate if the position will be filled by a Subcontractor.

The Proposer should identify the individuals serving as key personnel, the resources proposed for Key Personnel roles in *Section 2.1.4*, and the percentage of time directly assigned to the project, should be identified.

Include full resumes of all proposed key personnel identified for key roles. Each person identified for a role above should be included in the resume section. Each resume should demonstrate the qualifications and experience relevant to the position proposed. Each resume should include work history, the specific functions performed, and how the experience relates to the assigned role. Résumés of all known personnel working or overseeing the LDH Pharmacy Program should be included. Résumés of proposed personnel should include, but not be limited to:

- Experience with Proposer.
- Previous experience in projects of similar scope and size.
- Educational background, certifications, licenses, special skills, etc.

Provide three (3) references for each proposed Key Personnel candidate demonstrating experience in a similar role on one or more projects similar to *Section 2. Scope of Work* requirements. Each reference should include:

- Name of the person to be contacted.
- Contact phone number.
- Client name and address.
- Brief description of work.
- Dates (month and year) of employment.

These references should be able to attest to the candidate’s specific qualifications.

If Subcontractor personnel will be used, the Proposer should clearly identify these persons, if known, and provide the same information requested for the Proposer’s personnel, if requested by LDH.

If any of the Proposer's named personnel is a current or former Louisiana State employee, indicate the Agency where employed, position, title, termination date, and (in the redacted proposal ONLY) the last four digits of the social security number.

1.8.11 Veteran and Hudson Initiative Programs Participation

The State of Louisiana Veteran and Hudson Initiatives are designed to provide additional opportunities for Louisiana-based small entrepreneurships (sometimes referred to as LaVet's and SE's respectively) to participate in contracting and procurement with the State. A certified Veteran-Owned and Service-Connected Disabled Veteran-Owned small entrepreneurship (LaVet) and a Louisiana Initiative for Small Entrepreneurships (Hudson Initiative) small entrepreneurship are businesses that have been certified by the Louisiana Department of Economic Development. All eligible vendors are encouraged to become certified. Qualification requirements and online certification are available at:

https://smallbiz.louisianaeconomicdevelopment.com.

If a Proposer is not a certified small entrepreneurship as described herein, but plans to use certified small entrepreneurship(s), Proposer shall include in their proposal the names of their certified Veteran Initiative or Hudson Initiative small entrepreneurship Subcontractor(s), a description of the work each will perform, and the dollar value of each subcontract.

During the term of the contract and at expiration, the Contractor will also be required to report Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurship Subcontractor or distributor participation and the dollar amount of each.

In RFPs requiring the compliance of a good faith subcontracting plan, the State may require Proposers to submit information on their business relationships and arrangements with certified LaVet or Hudson Initiative Subcontractors at the time of proposal review. Agreements between a Proposer and a certified LaVet or Hudson Initiative Subcontractor in which the certified LaVet or Hudson Initiative Subcontractor promises not to provide subcontracting quotations to other Proposers shall be prohibited.

If performing its evaluation of proposals, the State reserves the right to require a non-certified Proposer to provide documentation and information supporting a good faith subcontracting plan. Such proof may include contracts between Proposer and certified Veteran Initiative and/or Hudson Initiative Subcontractor(s).

If a contract is awarded to a Proposer who proposed a good faith subcontracting plan, the using agency, the Louisiana Department of Economic Development (LED), or the Office of State Procurement (OSP) may audit Contractor to determine whether Contractor has complied in good faith with its subcontracting plan. The Contractor must be able to provide supporting documentation (i.e., phone logs, fax transmittals, letter, e-mails) to demonstrate its good faith subcontracting plan was followed. If it is determined at any time by the using agency, LED, or the OSP Director that the Contractor did not in fact perform in good faith its subcontracting plan, the contract award or the existing contract may be terminated.

The statutes (La. R.S. 39:2171 et. seq.) concerning the Veteran Initiative may be viewed at:

http://www.legis.la.gov/Legis/Law.aspx?d=671504.

The statutes (La. R.S. 39:2001 et. seq.) concerning the Hudson Initiative may be viewed at: http://www.legis.la.gov/Legis/Law.aspx?d=96265.

The rules for the Veteran Initiative (LAC 19:VII. Chapters 11 and 15) and for the Hudson Initiative (LAC 19:VIII Chapters 11 and 13) may be viewed at:

https://www.doa.la.gov/doa/osp/vendor-resources/hudson-se-veteran-initiatives/.

A current list of certified Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurships may be obtained from the Louisiana Economic Development Certification System at: https://smallbiz.louisianaeconomicdevelopment.com

Additionally, a list of Hudson and Veteran Initiative small entrepreneurships, which have been certified by the Louisiana Department of Economic Development and who have opted to register in the State of Louisiana LaGov Supplier Portal:

https://lagoverpvendor.doa.louisiana.gov/irj/portal/anonymous?guest_user=self_reg.

This may be accessed from the State of Louisiana Procurement and Contract (LaPAC) Network:

https://wwwcfprd.doa.louisiana.gov/OSP/LaPAC/vendor/VndPubMain.cfm.

When using this site, determine the search criteria (i.e. alphabetized list of all certified vendors, by commodities, etc.) and select SmallE, VSE, or DVSE.

1.8.12 Additional Information

As an appendix, Proposers should include a copy of the Continuity of Operations Plan.

1.8.13 Cost Proposal

Proposers shall complete a cost proposal in format of the cost template form (See Attachment III) for each year of the contract to demonstrate how cost was determined. Proposers must complete a cost proposal to be considered for award. Failure to complete will result in the disqualification of the proposal.

1.8.14 Certification Statement

The Proposer must submit a Certification Statement (See Attachment I) signed by the company official or agent duly authorized to sign proposals or contracts on behalf of the organization. A certified copy of a board resolution granting such authority shall be submitted with the Certification Statement if the Proposer is a corporation. The Proposer represents and agrees that in reviewing and completing this response it has accurately disclosed - and in the future will accurately disclose – all interests of Proposer. Proposer also represents and agrees that it has disclosed - and will disclose - any activity, policy, or practice of which Proposer is aware that presents a conflict of interest with the performance of its obligations hereunder.

1.9 Number of Copies of Proposals

Firms or individuals who are interested in providing services requested under this RFP must submit a proposal containing the mandatory information specified in the Sections 1.7 and 1.8. The proposal must be received in hard copy (printed) version by the RFP Coordinator on or before the date and time specified in the Schedule of Events. It is the sole responsibility of each Proposer to assure that its proposal is delivered at the specified location prior to the deadline. Proposals which, for any reason, are not so delivered will not be considered.

Proposer shall submit:

- one (1) original hard copy (the Certification Statement must have original signature signed in ink);
- Six (6) duplicate hard copies; and
- Three (3) electronic copies (on separate USB flash drives) of the entire technical and cost proposal.

Proposer shall also submit three (3) electronic copies (on separate USB flash drives) of its Redacted Proposal, if applicable. All electronic copies must be searchable. No facsimile or emailed proposals will be accepted. The cost proposal and financial statements shall be submitted separately from the technical proposal; however, for mailing purposes, all packages may be shipped in one container.

Proposers must label the package(s) containing the proposals as a Sealed Proposal.

Proposals must be submitted via U.S. mail, courier or hand delivered to:

If courier mail or hand delivered:

Germaine Becks-Moody
Louisiana Department of Health
Medical Vendor Administration
628 N 4th Street, 6th Floor
Baton Rouge, LA 70802

If delivered via US Mail:

Germaine Becks-Moody
Louisiana Department of Health
Medical Vendor Administration
P.O. Box 91030 Bin # 24
Baton Rouge, LA 70821-9030

1.10 Legibility/Clarity

Responses to the requirements of this RFP in the formats requested are desirable with all questions answered in as much detail as practicable. The Proposer's response should demonstrate an understanding of the requirements. Proposals prepared simply and economically, providing a straightforward, concise description of the Proposer's ability to meet the requirements of the RFP are also desired. Each Proposer shall be solely responsible for the accuracy and completeness of its proposal.

1.11 Confidential Information, Trade Secrets, and Proprietary Information

The designation of certain information as trade secrets and/or privileged or confidential proprietary information shall only apply to the technical portion of the proposal. The financial proposal will not be considered confidential under any circumstance. Any proposal copyrighted or marked as confidential or proprietary in its entirety may be rejected without further consideration or recourse.

For the purposes of this procurement, the provisions of the Louisiana Public Records Act (La. R.S. 44.1 et. seq.) shall be in effect. Pursuant to this Act, all proceedings, records, contracts, and other public documents relating to this procurement shall be open to public inspection. Proposers are reminded that while trade secrets and other proprietary information they submit in conjunction with this procurement may not be subject to public disclosure, protections must be claimed by the

Proposer at the time of submission of its Technical Proposal. Proposers should refer to the Louisiana Public Records Act for further clarification.

The Proposer shall clearly designate the part of the proposal that contains a trade secret and/or privileged or confidential proprietary information as "confidential" in order to claim protection, if any, from disclosure. The Proposer shall mark the cover sheet of the proposal with the following legend, specifying the specific section(s) of the proposal sought to be restricted in accordance with the conditions of the legend:

> *"The data contained in pages _____of the proposal have been submitted in confidence and contain trade secrets and/or privileged or confidential information and such data shall only be disclosed for evaluation purposes, provided that if a contract is awarded to this Proposer as a result of or in connection with the submission of this proposal, the State of Louisiana shall have the right to use or disclose the data therein to the extent provided in the contract. This restriction does not limit the State of Louisiana's right to use or disclose data obtained from any source, including the Proposer, without restrictions."*

Further, to protect such data, each page containing such data shall be specifically identified and marked "CONFIDENTIAL".

If the Proposer's response contains confidential information, the Proposer should also submit a redacted copy of their proposal along with their original proposal. When submitting the redacted copy, the Proposer should clearly mark the cover as such - "REDACTED COPY". The redacted copy should also state which sections or information have been removed. The Proposer should also submit one (1) electronic redacted copy of its proposal on a USB flash drive. The redacted copy of the proposal will be the copy produced by the State if a competing Proposer or other person seeks review or copies of the Proposer's confidential data.

If the Proposer does not submit the redacted copy, it will be assumed that any claim to keep information confidential is waived.

Proposers must be prepared to defend the reasons why the material should be held confidential. By submitting a proposal with data, information, or material designated as containing trade secrets and/or privileged or confidential proprietary information, or otherwise designated as "confidential", the Proposer agrees to indemnify and defend (including attorney's fees) the State and hold the State harmless against all actions or court proceedings that may ensue which seek to order the State to disclose the information.

The State reserves the right to make any proposal, including proprietary information contained therein, available to OSP personnel, the Office of the Governor, or other State agencies or organizations for the sole purpose of assisting the State in its evaluation of the proposal. The State shall require said individuals to protect the confidentiality of any specifically identified proprietary information or privileged business information obtained as a result of their participation in these evaluations.

Additionally, any proposal that fails to follow this section and/or La. R.S. 44:3.2(D)(1) shall have failed to properly assert the designation of trade secrets and/or privileged or confidential proprietary information and the information may be considered public records.

1.12 Proposal Clarifications Prior to Submittal

1.12.1 Pre-proposal Conference

The Department does not contemplate requiring a pre-proposal conference, Department expressly reserves the right to hold a pre-proposal conference on a date and time to be specified via an addendum to this RFP.

1.12.2 Proposer Inquiries

Written questions regarding RFP requirements or scope of services must be emailed to the RFP Coordinator listed below. All communications relating to this RFP must be directed only to the RFP Coordinator. All communications between Proposers and other LDH staff members concerning this RFP shall be strictly prohibited. Failure to comply with these requirements shall result in proposal disqualification.

RFP Coordinator: Germaine Becks-Moody

RFP Coordinator: germaine.becks-moody@la.gov

LDH will only consider written inquiries regarding the RFP received on or before the date specified in *Section 1.6. Schedule of Events*.

Any and all questions directed to the RFP Coordinator will be deemed to require an official response and a copy of all questions and answers will be posted by the date specified in *Section 1.6. Schedule of Events* to the following web link:
http://wwwcfprd.doa.louisiana.gov/OSP/LaPAC/pubMain.cfm

Questions and responses may also be posted at:
http://new.ldh.louisiana.gov/index.cfm/newsroom/category/47

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

Only the RFP Coordinator has the authority to officially respond to a Proposer's questions on behalf of LDH. Any communications from any other individuals shall not be binding to LDH.

Note: LaPAC is the State's online electronic bid posting and notification system resident on the Office of State Procurement website http://www.doa.la.gov/Pages/osp/Index.aspx. In that LaPAC provides an immediate e-mail notification to subscribing Bidders/Proposers that a solicitation and any subsequent addenda have been let and posted, notice and receipt thereof is considered formally given as of their respective dates of posting. To receive the e-mail notification, Vendors/Proposers must register in the LaGov portal.

Self-Registration can be completed at the following link:
https://lagoverpvendor.doa.louisiana.gov/irj/portal/anonymous?guest_user=self_reg

Help Scripts and Frequently Asked Questions are available on OSP website under Vendor Center at: http://www.doa.la.gov/Pages/osp/vendorcenter/regnhelp/index.aspx

1.12.3 Procurement Library/Resources Available to Proposer

Documents are available electronically. Charges for copying are twenty-five cents ($0.25) per page, payable at the time copies are made. Cash is not acceptable. Checks and/or money orders are to be made payable to the Louisiana Department of Health.

Relevant material related to this RFP will be posted at the following web address: http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47

1.12.4 Blackout Period

The Blackout Period is a specified period of time during a competitive sealed procurement process in which any Proposer, bidder, or its agent or representative, is prohibited from communicating with any State employee or contractor of the State involved in any step in the procurement process about the affected procurement. The Blackout Period applies not only to State employees, but also to any contractor of the State. "Involvement" in the procurement process includes, but may not be limited to, project management, design, development, implementation, procurement management, development of specifications, and evaluation of proposals for a particular procurement. All solicitations for competitive sealed procurements will identify a designated contact person, as per *Section 1.12.2. Proposer Inquiries* of this RFP. All communications to and from potential Proposers, bidders, vendors and/or their representatives during the Blackout Period must be in accordance with this solicitation's defined method of communication with the designated contact person. The Blackout Period will begin upon posting of the solicitation. The Blackout Period will end when the contract is awarded.

In those instances, in which a prospective Proposer is also an incumbent contractor, the State and the incumbent contractor may contact each other with respect to the existing contract only. Under no circumstances may the State and the incumbent contractor and/or its representative(s) discuss the blacked-out procurement.

Any bidder, Proposer, or State contractor who violates the Blackout Period may be liable to the State in damages and/or subject to any other remedy allowed by law.

Any costs associated with cancellation or termination will be the responsibility of the Proposer or bidder.

Notwithstanding the foregoing, the Blackout Period shall not apply to:

- A protest to a solicitation submitted pursuant to La. R.S. 39:1671.
- Duly noticed site visits and/or conferences for bidders or Proposers.
- Oral presentations during the evaluation process.
- Communications regarding a particular solicitation between any person and staff of the procuring agency provided the communication is limited strictly to matters of procedure. Procedural matters include deadlines for decisions or submission of proposals and the

proper means of communicating regarding the procurement but shall not include any substantive matter related to the particular procurement or requirements of the RFP.

1.13 Error and Omissions in Proposal

The Department reserves the right to seek clarification of any proposal for the purpose of identifying and eliminating minor irregularities or informalities.

1.14 Changes, Addenda, Withdrawals

The State reserves the right to change the schedule of events or revise any part of the RFP by issuing an addendum to the RFP at any time. Addenda, if any, will be posted at https://wwwcfprd.doa.louisiana.gov/osp/lapac/pubMain.cfm

Addenda may also be posted at: http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47

It shall be the responsibility of the Proposer to check the websites for addenda to the RFP.

1.15 Withdrawal of Proposal

A Proposer may withdraw a proposal that has been submitted at any time up to the date and time the proposal is due. To withdraw a proposal, a written request signed by the authorized representative of the Proposer must be submitted to the RFP coordinator identified in the RFP.

1.16 Waiver of Administrative Informalities

The Department shall reserve the right, at its sole discretion, to waive minor administrative informalities contained in any proposal.

1.17 Proposal Rejection/RFP Cancellation

Issuance of this RFP in no way shall constitute a commitment by LDH to award a contract(s) or to enter into a contract after an award has been made. The Department reserves the right to take any of the following actions that it determines to be in its best interest:

- Reject, in whole or part, all proposals submitted in response to this solicitation.
- Cancel this RFP.
- Cancel or decline to enter into a contract with the successful Proposer at any time after the award is made and before the contract receives final approval from the Division of Administration, Office of State Procurement.

1.18 Ownership of Proposal

All proposals become the property of the Department and will not be returned to the Proposer. The Department retains the right to use any and all ideas or adaptations of ideas contained in any proposal received in response to this solicitation. Selection or rejection of the offer will not affect this right. Once a contract is awarded, all proposals will become subject to the Louisiana Public Records Act.

1.19 Cost of Offer Preparation

The Department shall not be liable for any costs incurred by Proposers prior to issuance of or entering into a contract. Costs associated with developing the proposal, preparing for oral presentations, and any other expenses incurred by the Proposer in responding to this RFP shall be entirely the responsibility of the Proposer and shall not be reimbursed in any manner by the Department. The Proposer shall not include these costs or any portion thereof in the proposed contract cost. The Proposer is fully responsible for all preparation costs associated therewith, even if an award is made but subsequently terminated by the Department.

The Proposer to which the contract is awarded assumes sole responsibility for any and all costs and incidental expenses that it may incur in connection with: (1) the preparation, drafting or negotiation of the final contract; or (2) any activities that the Proposer may undertake in preparation for, or in anticipation or expectation of, the performance of its work under the contract before the contract receives final approval from the Division of Administration, Office of State Procurement.

1.20 Taxes

The Contractor shall be responsible for payment of all applicable taxes from the funds to be received under contract awarded from this RFP.

In accordance with La. R.S. 39:1624(A)(10), the Louisiana Department of Revenue must determine that the prospective contractor is current in the filing of all applicable tax returns and reports and in payment of all taxes, interest, penalties, and fees owed to the State and collected by the Department of Revenue prior to the approval of the contract by the Office of State Procurement. The Proposer shall attest to its current and/or prospective compliance by signing the *Attachment I. Certification Statement*, submitted with its proposal, and also agrees to provide its seven-digit LDR Account Number to the contracting agency so that the prospective contractor's tax payment compliance status may be verified. The prospective contractor further acknowledges understanding that issuance of a tax clearance certificate by the Louisiana Department of Revenue is a necessary precondition to the approval and effectiveness of any contractual agreement by the Office of State Procurement. The State reserves the right to withdraw its consent to the contract without penalty and proceed with alternate arrangements should the prospective contractor fail to resolve any identified apparent outstanding tax compliance discrepancies with the Louisiana Department of Revenue within seven (7) Calendar Days of such notification.

1.21 Determination of Responsibility

Determination of the Proposer's responsibility relating to this RFP shall be made according to the standards set forth in LAC 34:V.1505. The State must find that the selected Proposer:

- Has adequate financial resources for performance, or has the ability to obtain such resources as required during performance.
- Has the necessary experience, organization, technical qualifications, skills, and facilities, or has the ability to obtain them.
- Is able to comply with the proposed or required time of delivery or performance schedule.
- Has a satisfactory record of integrity, judgment, and performance.

- Is otherwise qualified and eligible to receive an award under applicable laws and regulations.

Proposers should ensure that their proposals contain sufficient information for the State to make its determination by presenting acceptable evidence of the above to perform the contracted services.

- The Proposer shall include with its proposal copies of audited financial statements for each of the last three (3) years, including at least a balance sheet and profit and loss statement, or other appropriate documentation, which would demonstrate to LDH the Proposer's financial resources sufficient to conduct the project, as required by Section 1.20 above.
- A certificate from the taxing authority of the state in which the Proposer has its principal office, attesting that the Proposer is not in default of any obligation under its tax laws.

1.22 Use of Subcontractors

LDH shall have a single prime Contractor as the result of any contract negotiation, and that prime Contractor shall be responsible for all deliverables specified in the RFP and proposal. This general requirement notwithstanding, Proposers may enter into Subcontractor arrangements, however, shall acknowledge in their proposals total responsibility for the entire contract.

If the Proposer intends to subcontract for portions of the work, the Proposer shall identify any Subcontractor relationships and include specific designations of the tasks to be performed by the Subcontractor. Information required of the Proposer under the terms of this RFP shall also be required for each Subcontractor, if requested by LDH. The prime Contractor shall be the single point of contact for all subcontract work.

Unless provided for in the Contract, the prime Contractor shall not contract with any other party for any of the services herein contracted without the express prior written approval of the State.

1.23 Written or Oral Discussions/Presentations

The Department at its sole discretion may require all reasonably susceptible of being selected for an award to provide an on-site presentation and/or demonstration. On-site presentations/demonstrations will allow the selected Proposers to demonstrate their unique capability to provide the services requested in the RFP.

The Department may adjust the Proposers' original scores based upon information received in the on-site presentations/demonstrations, using the original evaluation criteria.

1.24 Acceptance of Proposal Content

All proposals will be reviewed to determine compliance with administrative and mandatory requirements as specified in the RFP. Proposals that are not in compliance will be rejected from further consideration.

1.25 Evaluation and Selection

The evaluation of proposals will be accomplished by an evaluation team, to be designated by the State, and charged with determining the proposal most advantageous to the State, taking into consideration price and the other evaluation factors set forth in the RFP in *Section 3. Evaluation*.

The evaluation team may consult subject matter expert(s) to serve in an advisory capacity regarding any Proposer or proposal. Such input may include, but not be limited to, analysis of Proposer financial statements, review of technical requirements, or preparation of cost score data.

1.26 Best and Final Offers (BAFO)

The State reserves the right to conduct a BAFO with one or more Proposers determined by the evaluation committee to be reasonably susceptible of being selected for award. If conducted, the Proposers selected will receive written notification of their selection, with a list of specific items to be addressed in the BAFO along with instructions for submittal. The BAFO negotiation may be used to assist the State in clarifying the scope of work or to obtain the most cost-effective pricing available.

The written invitation to participate in BAFO will not obligate the State to a commitment to enter into a contract.

1.27 Contract Award and Execution

The State reserves the right to enter into a contract based on the initial offers received without further discussion of the proposals submitted. The State reserves the right to contract for all or a partial list of services offered in the proposals.

The RFP, including any addenda added and the proposal of the selected Proposer shall become part of the contract initiated by the Department.

The selected Proposer shall be expected to enter into a contract that is substantially the same as the sample contract included in *Attachment II. CF-1*. In no event shall a Proposer submit its own standard contract terms and conditions as a response to this RFP. The Proposer should submit with its proposal any exceptions or exact contract deviations that its firm wishes to negotiate. Negotiations may begin with the announcement of the selected Proposer.

If the contract negotiation period exceeds thirty (30) Calendar Days or if the selected Proposer fails to sign the final contract within fourteen (14) Calendar Days of delivery, LDH may elect to cancel the award and award the contract to the next-highest-ranked Proposer.

1.28 Notice of Intent to Award

The Evaluation Team will compile the scores and make a recommendation to the head of the agency on the basis of the responsive and responsible proposer with the highest score.

The Department reserves the right to:

- Make multiple awards.
- Make an award without presentations by Proposers or further discussion of proposals received.

- Enter into a contract without further discussion of the proposal submitted based on the initial offers received.
- Contract for all or a partial list of services offered in the proposal.

The award of a contract is subject to the approval of the Division of Administration, Office of State Procurement.

The proposals received (except for that information appropriately designated as confidential in accordance with La. R.S. 44:3.2), scores of each proposal considered along with a summary of scores, and a narrative justifying selection shall be made available, upon request, to all interested parties after the "Notice of Intent to Award" letter has been issued.

The Department will notify the successful Proposer and proceed to negotiate terms for final contract. Unsuccessful Proposers will be notified in writing accordingly.

Any person aggrieved by the proposed award has the right to submit a protest in writing to the State Chief Procurement Officer within fourteen (14) Calendar Days after the Department issues the Notice of Intent to Award.

1.29 Right to Prohibit Award

In accordance with the provisions of La. R.S. 39:2192, any public entity shall be authorized to reject a proposal from, or not award a contract to, a business in which any individual with an ownership interest of five percent or more, has been convicted of, or has entered a plea of guilty or nolo contendere to any State felony or equivalent Federal felony crime committed in the solicitation or execution of a contract or RFP awarded under the laws governing public contracts under the provisions of Chapter 10 of Title 38 of the Louisiana Revised Statutes of 1950, and all contracts under Title 39, Chapter 17 of the Louisiana Procurement Code, including contracts for professional, personal, consulting, and social services.

1.30 Insurance Requirements for Contractors

Insurance shall be placed with insurers with an A.M. Best's rating of no less than A-: VI.

This rating requirement shall be waived for Workers' Compensation coverage only.

1.30.1 Contractor's Insurance

The Contractor shall purchase and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by the Contractor, its agents, representatives, employees or Subcontractors. The cost of such insurance shall be included in the total contract amount. The Contractor shall not commence work under the Contract until it has obtained all insurance required herein, including but not limited to Automobile Liability Insurance, Workers' Compensation Insurance and General Liability Insurance. Certificates of Insurance, fully executed by officers of the Insurance Company shall be filed with the Department for approval. The Contractor shall not allow any Subcontractor to commence work on subcontract until all similar insurance required for the

Subcontractor has been obtained and approved. If so requested, the Contractor shall also submit copies of insurance policies for inspection and approval of the Department before work is commenced. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) Calendar Days' written notice in advance to the Department and consented to by the Department in writing and the policies shall so provide.

1.30.2 Minimum Scope and Limits of Insurance

1.30.2.1 Workers' Compensation

Workers' Compensation insurance shall be in compliance with the Workers' Compensation law of the State of the Contractor's headquarters. Employers Liability is included with a minimum limit of 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 LHWCA, Jones Act, or other maritime law coverage shall be included. A.M. Best's insurance company rating requirement may be waived for workers' compensation coverage only.

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

1.30.2.2 Commercial General Liability

Commercial General Liability insurance, including Personal and Advertising Injury Liability and Products and Completed Operations, 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, is to be used in the policy. Claims-made form is unacceptable.

The Contractor shall maintain during the life of the contract such Commercial General Liability Insurance which shall protect Contractor, the Department, and any Subcontractor during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as for claims for property damages, which may arise from operations under the contract, whether such operations be by the Contractor or by a Subcontractor, or by anyone directly or indirectly employed by either of them, or in such a manner as to impose liability to the Department. Such insurance shall name the Department as additional insured for claims arising from or as the result of the operations of the Contactor or its Subcontractors.

1.30.2.3 Professional Liability (Errors and Omissions)

Professional Liability (Error & Omissions) insurance, which covers the professional errors, acts, or omissions of the Contractor, shall have a minimum limit of three million dollars ($3,000,000). Claims-made coverage is acceptable. The date of the inception of the policy must be no later than the first date of the anticipated work under the contract. It shall provide coverage for the duration of the contract and shall have an expiration date no earlier than thirty (30) Calendar Days after the anticipated completion of the contract. The policy shall provide an extended reporting period of not less than thirty-six (36) months from the expiration date of the policy if the policy is not renewed.

1.30.2.4 Automobile Liability

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, is to be used in the policy. This insurance shall include third-party bodily injury and property damage liability for owned, hired and non-owned automobiles.

Such insurance shall cover the use of any non-licensed motor vehicles engaged in operations within the terms of the contract on the site of the work to be performed thereunder, unless such coverage is included in insurance elsewhere specified.

1.30.2.5 Cyber Liability

Cyber Liability insurance, including first-party costs, due to an electronic breach that compromises the State's confidential data shall have a minimum limit per occurrence of five million dollars ($5,000,000). Claims-made coverage is acceptable. The date of the inception of the policy must be no later than the first date of the anticipated work under the contract. It shall provide coverage for the duration of the contract and shall have an expiration date no earlier than thirty (30) Calendar Days after the anticipated completion of the contract. The policy shall provide an extended reporting period of not less than thirty-six (36) months from the expiration date of the policy if the policy is not renewed. The policy shall not be cancelled for any reason, except non-payment of premium

1.30.3 Deductibles and Self-Insured Retentions

Any deductibles or self-insured retentions must be declared to and accepted by the Agency. The Contractor shall be responsible for all deductibles and self-insured retentions.

1.30.4 Other Insurance Provisions

Insurance Covering Special Hazards

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

The policies are to contain, or be endorsed to contain, the following provisions:

1.30.4.1 Commercial General Liability, Automobile Liability, and Cyber Liability Coverages

The Agency, its officers, agents, employees and volunteers shall be named as an additional insured as regards negligence by the Contractor. ISO Forms CG 20 10 (for ongoing work) AND CG 20 37 (for completed work) (current forms approved for use in Louisiana), or equivalents, are to be used when applicable. The coverage shall contain no special limitations on the scope of protection afforded to the Agency.

The Contractor's insurance shall be primary as respects the Agency, its officers, agents, employees and volunteers for any and all losses that occur under the contract. Any insurance or self-insurance maintained by the Agency shall be excess and non-contributory of the Contractor's insurance.

1.30.4.2 Workers Compensation and Employers Liability Coverage

To the fullest extent allowed by law, the insurer shall agree to waive all rights of subrogation against the Agency, its officers, agents, employees and volunteers for losses arising from work performed by the Contractor for the Agency.

1.30.4.3 All Coverages

All policies must be endorsed to require thirty (30) Calendar Days written notice of cancellation to the Agency. Ten (10) Calendar Day written notice of cancellation is acceptable for non-payment of premium. Notifications shall comply with the standard cancellation provisions in the Contractor's policy. In addition, Contractor is required to notify Agency of policy cancellations or reductions in limits.

The acceptance of the completed work, payment, failure of the Agency to require proof of compliance, or Agency's acceptance of a non-compliant certificate of insurance shall not release the Contractor from the obligations of the insurance requirements or indemnification agreement.

The insurance companies issuing the policies shall have no recourse against the Agency for payment of premiums or for assessments under any form of the policies.

Any failure of the Contractor to comply with reporting provisions of the policy shall not affect coverage provided to the Agency, its officers, agents, employees and volunteers.

1.30.5 Acceptability of Insurers

All required insurance shall be provided by a company or companies lawfully authorized to do business in the jurisdiction in which the Project is located. Insurance shall be placed with insurers with an A.M. Best's rating of **A-:VI or higher**. This rating requirement may be waived for workers' compensation coverage only.

If at any time an insurer issuing any such policy does not meet the minimum A.M. Best rating, the Contractor shall obtain a policy with an insurer that meets the A.M. Best rating and shall submit another Certificate of Insurance within thirty (30) Calendar Days.

1.30.6 Verification of Coverage

Contractor shall furnish the Agency with Certificates of Insurance reflecting proof of required coverage. The Certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf. The Certificates are to be received and approved by the Agency before work commences and upon any contract renewal or insurance policy renewal thereafter.

The Certificate Holder shall be listed as follows:

State of Louisiana
The Louisiana Department of Health, Its Officers, Agents, Employees and Volunteers
628 North 4th Street, Baton Rouge, LA 70802
Click here to enter the Project or Contract #

In addition to the Certificates, Contractor shall submit the declarations page and the cancellation provision for each insurance policy. The Agency reserves the right to request complete certified copies of all required insurance policies at any time.

Upon failure of the Contractor to furnish, deliver and maintain required insurance, the contract, at the election of the Agency, may be suspended, discontinued or terminated. Failure of the Contractor to purchase and/or maintain any required insurance shall not relieve the Contractor from any liability or indemnification under the contract.

1.30.7 Subcontractors

Contractor shall include all Subcontractors as insureds under its policies OR shall be responsible for verifying and maintaining the Certificates provided by each Subcontractor. Subcontractors shall be subject to all of the requirements stated herein. The Agency reserves the right to request copies of Subcontractor's Certificates at any time.

1.30.8 Workers' Compensation Indemnity

In the event Contractor is not required to provide or elects not to provide workers' compensation coverage, the parties hereby agree that Contractor, its owners, agents and employees will have no cause of action against, and will not assert a claim against, the State of Louisiana, its departments, agencies, agents and employees as an employer, whether pursuant to the Louisiana Workers' Compensation Act or otherwise, under any circumstance. The parties also hereby agree that the State of Louisiana, its departments, agencies, agents and employees shall in no circumstance be, or considered as, the employer or statutory employer of Contractor, its owners, agents and employees. The parties further agree that Contractor is a wholly independent contractor and is exclusively responsible for its employees, owners, and agents. Contractor hereby agrees to protect, defend, indemnify and hold the State of Louisiana, its departments, agencies, agents and employees harmless from any such assertion or claim that may arise from the performance of the Contract.

1.31 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 the 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.

1.32 Liability and Indemnification

1.32.1 Contractor Liability

Contractor shall be liable without limitation to the State 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, agents, employees, partners or Subcontractors.

1.32.2 Force Majeure

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. The parties shall use reasonable efforts, including but not limited to, use of Continuation of Operations Plans (COOP) and Continuity of Operations (COO) plans to eliminate or minimize the effect of such events upon the performance of their respective duties under the Contract.

1.32.3 Indemnification

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, which may occur or in any way arise out of any act or omission of Contractor, its owners, agents, employees, partners or Subcontractors. The Contractor shall not indemnify for the portion of any loss or damage arising from the State's act or failure to act.

1.32.4 Intellectual Property Indemnification

Contractor shall fully indemnify and hold harmless the State, without limitation, from and against damages, costs, fines, penalties, judgments, forfeitures, assessments, expenses (including attorney fees), obligations, and other liabilities in any action for infringement of any intellectual property right, including but not limited to, trademark, trade-secret, copyright, and patent rights.

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.

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, 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.

1.32.5 Limitations of Liability

For all claims against the Contractor not governed by any other provision of this Section, regardless of the basis on which the claim is made, the Contractor's liability for direct damages shall be limited to two times the maximum dollar amount of the Contract.

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.

1.32.6 Other Remedies

If the Contractor fails to perform in accordance with the terms and conditions of the 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.

1.33 Payment/Compensation Model

The Contractor shall contract with each of the MCOs to implement the Louisiana Medicaid Program's pharmacy benefit as directed by LDH without exception.

The Contractor shall enter into a zero-dollar contract with LDH to establish a basis for contractual terms. LDH shall specify, and the Contractor shall follow, without exception, drug coverage, edits, utilization management strategies, and all other requirements for administration of the pharmacy benefit.

1.33.1.1 Payment Methodology

As payment-in-full for services provided under the Contract, the Contractor shall receive a transaction fee for each paid Drug Claim from each MCO in accordance with an LDH-approved methodology. The Contractor shall also receive payments for pharmacy reimbursement directly from the MCOs on a weekly basis. Pharmacy reimbursement shall include Professional Dispensing Fee, Ingredient Cost and any applicable fees. The Contractor shall provide a transparent pass-through model of net reimbursement.

1.34 Termination

1.34.1 Termination of the Contract for Cause

State 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 the State 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 which 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 the State 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 cause cancellation of the contract.

Contractor may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of the State to comply with the terms and conditions of the contract provided that the Contractor shall give the State written notice specifying the State agency's failure and a reasonable opportunity for the State to cure the defect.

1.34.2 Termination of the Contract for Convenience

LDH may terminate the 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.

1.34.3 Termination for Non-Appropriation of Funds

The continuation of the 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 on the date of the beginning of the first SFY for which funds have not been appropriated.

1.34.4 Termination for Unavailability of Federal Funds

The continuation of the 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 the 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.

1.35 Assignment

No Contractor shall assign any interest in the contract by assignment, transfer, or novation, without prior written consent of the State. This provision shall not be construed to prohibit the Contractor from assigning to a bank, trust company, or other financial institution any money due or to become due from approved contracts without such prior written consent. Notice of any such assignment or transfer shall be furnished promptly to the State.

Any assignment, pledge, joint venture, hypothecation of right or responsibility to any person, firm or corporation should be fully explained and detailed in the proposal. Information as to the experience and qualifications of proposed Subcontractors should be included in the proposal. In addition, written commitments from any Subcontractors should be included as part of the proposal. All assignments must be approved of by the Department.

1.36 Right to Audit

The State, including LDH, Medicaid Fraud Control Unit (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 the Contract at any time.

This right exists for ten (10) years from the termination of the 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.

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.

1.37 Civil Rights Compliance

The Contractor agrees to abide by the requirements of the following as applicable: Title VI of the Civil Rights Act of 1964 and Title VII of the Civil Rights Act of 1964, as amended by the Equal Employment Opportunity Act of 1972, Federal Executive Order 11246 as amended, the Rehabilitation Act of 1973, as amended, the Vietnam Era Veteran's Readjustment Assistance Act of

1974, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, the Fair Housing Act of 1968 as amended, and the Americans with Disabilities Act of 1990.

Contractor agrees not to discriminate in its employment practices and will render services under the contract without regard to race, color, religion, sex, sexual orientation, national origin, veteran status, political affiliation, disability, or age in any matter relating to employment. Any act of discrimination committed by Contractor, or failure to comply with these statutory obligations when applicable shall be grounds for termination of the contract.

1.38 Record Ownership

All records, reports, documents, or other material related to any contract resulting from this RFP 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 Department and shall, upon request, be returned by the Contractor to the Department, at the Contractor's expense, at termination or expiration of the contract.

1.39 Entire Agreement/ Order of Precedence

The contract, together with the RFP and addenda issued thereto by the Department, the proposal submitted by the Contractor in response to the Department's RFP, and any exhibits specifically incorporated herein by reference, shall constitute the entire agreement between the parties with respect to the subject matter.

In the event of any inconsistent or incompatible provisions, this signed agreement (excluding the RFP and the Contractor's proposal) shall take precedence, followed by the provisions of the RFP, and then by the terms of the Contractor's proposal.

1.40 Contract Modifications

No amendment or variation of the terms of the contract shall be valid unless made in writing, signed by the parties and approved as required by law. No oral understanding or agreement not incorporated in the contract shall be binding on any of the parties.

1.41 Substitution of Personnel

The Contractor's key personnel assigned to the Contract shall not be replaced without the prior written consent of the Department. Such consent shall not be unreasonably withheld or delayed provided an equally qualified replacement is offered. In the event that any State or Contractor personnel become unavailable due to resignation, illness, or other factors, excluding assignment to a project outside the Contract, outside of the Department's or Contractor's reasonable control, as the case may be, the Department or the Contractor shall be responsible for providing an equally qualified replacement in time to avoid delays in completing tasks, not to exceed thirty (30) Calendar Days measured from when the vacancy occurs. The Contractor will make every reasonable attempt to assign the personnel listed in its proposal.

1.42 Governing Law

The contract shall be governed by and interpreted in accordance with the laws of the State of Louisiana. Venue of any action brought with regard to the contract shall be in the Nineteenth Judicial District Court, Parish of East Baton Rouge, State of Louisiana.

1.43 Claims or 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.

1.44 Code of Ethics

Proposers shall be responsible for determining that there will be no conflict or violation of the Louisiana Ethics Code if their company is awarded the contract. The Louisiana Board of Ethics shall be the only entity which can officially rule on ethics issues. Notwithstanding, any potential conflict of interest that is known or should reasonably be known by a Proposer as it relates to the RFP should be immediately reported to the Department by Proposer.

The Proposer 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 the 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 the Contract.

1.45 Corporate Requirements

If the successful Proposer is a corporation, the following requirements must be met prior to execution of the Contract:

- If the Contractor is a for-profit corporation whose stock is not publicly traded, the Contractor shall ensure that a disclosure of ownership form has been properly filed with the Secretary of State of Louisiana.
- If the Contractor is a corporation not incorporated under the laws of the State of Louisiana, the Proposer must obtain a Certificate of Authority pursuant to La. R.S. 12:301-302 from the Louisiana Secretary of State.
- The Contractor must provide written assurance to the Department from Contractor's legal counsel that the Contractor is not prohibited by its articles of incorporation, bylaws or the laws under which it is incorporated from performing the services required under the contract.

1.46 Prohibition of Discriminatory Boycotts of Israel

In preparing its response, the Proposer has considered all proposals submitted from qualified, potential Subcontractors and suppliers, and has not, in the solicitation, selection, or commercial treatment of any Subcontractor or supplier, refused to transact or terminated business activities, or taken other actions intended to limit commercial relations, with a person or entity that is engaging in commercial transactions in Israel or Israeli-controlled territories, with the specific intent to accomplish a boycott or divestment of Israel. Proposer also has not retaliated against any person or

other entity for reporting such refusal, termination, or commercially limiting actions. The State reserves the right to reject the response of the Proposer if this certification is subsequently determined to be false, and to terminate any contract awarded based on such a false response.

1.47 Security

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 contract. Where special security precautions are warranted (e.g., correctional facilities), the State shall provide such procedures to the Contractor, accordingly.

The Contractor shall comply with the Office of Technology Services' (OTS) Information Security Policy at http://www.doa.la.gov/Pages/ots/InformationSecurity.aspx.

1.47.1 Cybersecurity Training

In accordance with La. R.S. 42:1267(B)(3) and the State of Louisiana's Information Security Policy, if the Contractor, any of its employees, agents, or Subcontractors will have access to State government information technology assets, the Contractor's employees, agents, or Subcontractors with such access must complete cybersecurity training annually, and the Contractor must present evidence of such compliance annually and upon request. The Contractor shall use the cybersecurity training course offered by the Louisiana Department of State Civil Service without additional cost.

For purposes of this Section, "access to State government information technology assets" means the possession of credentials, equipment, or authorization to access the internal workings of State information technology systems or networks. Examples would include but not be limited to State-issued laptops, VPN credentials to access the State network, badging to access the State's telecommunications closets or systems, or permissions to maintain or modify IT systems used by the State. Final determination of scope inclusions or exclusions relative to access to State government information technology assets will be made by the Office of Technology Services.

2 SCOPE OF WORK

2.1 Task and Services

2.1.1 Overview

- The Contractor will provide services to the contracted MCOs, including, but not limited to:
  - Drug Claims processing and administering payments to Network Providers.
  - Applying the PDL and benefit design.
  - Processing PA requests using LDH-established criteria.
  - Providing Provider and Enrollee customer service.
  - Network auditing.
  - Development and delivery of required reports to LDH and the MCOs.
  - Providing Drug Claims data to the MCOs daily.
  - Providing LDH or its designee(s) and the MCOs with real-time, unredacted, read-only access to the Drug Claims processing and online reporting system(s).
  - Ensuring that program performance is met including, but not limited to, measures of PDL compliance, DUR monitoring, and Enrollee satisfaction.

- The Contractor may not implement any internal Drug Claims processing restrictions such as PA, quantity and/or duration limits, age/gender restrictions, Prospective Drug Utilization Review (ProDUR) edits, or other restrictions unless authorized by LDH.

- The Contractor shall process Drug Claims equally and uniformly for all MCOs to avoid duplication of effort and reduce administrative overhead.

- The Contractor shall provide appropriate services to Enrollees to prevent harm or mitigate risk of imminent harm.

- The Contractor shall:
  - Provide PBM services equally and in a manner that prevents duplication or multiple solutions for the MCOs.
  - Perform Readiness Review as a part of the MCO Readiness Review process.
  - Maintain expert knowledge of industry standards, best practices, and innovations, and make program improvement recommendations to LDH for consideration.
  - Comply and be thoroughly conversant with all applicable State and Federal laws, rules, regulations, policies, procedures, and manuals as well as the State Plan for pharmacy benefit services provided to Enrollees by Network Providers.
  - Implement any system modifications necessary to comply with any change in Federal and State laws, rules, regulations, policies, procedures, manuals, or the State Plan by the deadlines imposed for such changes at no additional cost to the MCOs or LDH.
  - Not be required to maintain and manage the P&T Committee or the Drug Utilization Review (DUR) Board but shall collaborate with LDH and LDH's other vendors to participate in and contribute to these boards/committees onsite in Baton Rouge.
  - Attend other meetings onsite in Baton Rouge, as requested by LDH.

2.1.2 Background Information

2.1.2.1 Medicaid Federal and State Supplemental Rebate Programs

LDH is responsible for the implementation and administration of the Federal and supplemental rebate programs, which generated over eight hundred million dollars in expenditure offsets in SFY 2020. The State Supplemental Rebate program utilizes the services of other contractors, as described below.

The Fiscal Intermediary (FI) provides the following services:

- Technology equipment to support the program.
- Application modifications to the current Medicaid Management Information System (MMIS).
- Web-based pharmacy Prior Authorization (PA) software maintenance.
- Data research applications implementation.
- Data warehouse support.
- Drug Utilization Review (DUR) process management.
- Statistical Analysis System (SAS) training for research analysts.
- Pharmacy PA System training for LDH and staff.
- PA process training for Prescribers and Network Providers.
- Maintenance and operations of the Preferred Drug List (PDL)/Prior Authorization (PA) and Supplemental Rebate Systems.

The FFS PA contractor provides the following services:

- Operate pharmacist-staffed PA desk.
- Receive and process all FFS PA requests. Each PA is given for a specific drug for a specific Beneficiary for a specific period of time. In accordance with State and Federal laws, requests must be acted upon within twenty-four (24) hours. Provisions are in place whereby an emergency override is allowed for a minimum of a seventy-two (72) hour supply of medicine.
- Support DUR process.
- Provide physician consultations.
- Serve as consultants on the PDL and PA programs.
- Perform departmental-directed data analysis and outcome studies.

Drug Rebate Processing contractor/PDL contractor provides the following services:

- Provide network administration for the Federally mandated and optional State Supplemental Drug Rebate Program.
- Perform administrative initiatives to reduce expenditures for the Drug Rebate Programs. This includes reconciliation of drug records invoiced to drug manufacturers on a quarterly basis for the Federally mandated rebate program and the State Supplemental Rebate Program, pharmacy audit recoupments and pharmacy help desk.

- Provide accounting and audit support for Drug Rebate Program functions, which includes invoicing and reconciliation of over six hundred (600) drug manufacturers quarterly.
- Prepare quarterly rebate financial reports in accordance with Federal and State reporting requirements.
- Coordinate research and resolution of drug rebate disputes.
- Conduct financial analyses as requested in conjunction with departmental initiatives.
- Secure clinical and costing data for drugs in selected therapeutic classes.
- Perform clinical and economic analysis of manufacturer data.
- Negotiate State Supplemental Rebates with manufacturers.
- Prepare therapeutic class monographs for Pharmaceutical and Therapeutics (P&T) Committee deliberations.
- Present clinical and costing data to the P&T Committee.

2.1.2.2 Pharmaceutical and Therapeutics (P&T) Committee

La. R.S. 46:153.3B authorized LDH to establish a drug formulary utilizing a PA process or any other process or combination of processes that prove to be cost-effective in the medical assistance program. La. R.S. 46:153.3 also created the P&T Committee, which is responsible for developing the PDL in conjunction with the PA process. The P&T Committee reviews clinical and cost data on various therapeutic classes of drugs for recommendation to LDH for inclusion on the PDL or for review through the PA process.

On June 10, 2002, the Department implemented a PDL with a PA process and a Supplemental Drug Rebate program through a phased-in approach. The PDL/PA and supplemental rebate features were implemented in accordance with all applicable Federal and State requirements. The PDL/PA program does not limit a Beneficiary's access to any drugs that are payable under the Louisiana Medicaid Program. The PDL/PA program has been designed with the Beneficiary's health care needs in mind. The PDL/PA program allows for continuity of care for prescription drug services, ensures access to needed medications with immediate PA, and provides the safeguards, consistency and simplicity of administration and the best interests of the Beneficiary in accordance with 42 USC §1396a(a)(19).

The PDL is currently updated two (2) times a year upon LDH's approval of the P&T Committee's recommendations. The PDL is mailed, upon request, to Prescribers and Network Providers and is available on the web at https://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf. Currently, approximately one hundred thirty (130) therapeutics classes are reviewed by the P&T Committee. The PDL is maintained by LDH.

2.1.2.3 Drug Utilization Review (DUR)

The MCOs participate in the DUR program to assure that outpatient drugs are appropriate, medically necessary, and are not likely to result in adverse medical results in accordance with 42 USC §1396r-8(g). DUR (prospective, retrospective and educational) standards are established by the DUR Board that includes MCO representation.

2.1.3 Coordination with MCOs

Coordination between LDH, MCOs, and the Contractor is essential. The Contractor shall exchange information bi-directionally with the MCOs and LDH. In addition, the Contractor shall disseminate information to Network Providers and Enrollees upon approval from LDH.

The Contractor shall:

- Establish and maintain a single point of contact/liaison for each MCO.
- Establish a point of contact/liaison for LDH who is authorized and able to address issues across the entire Managed Care Program.
- Establish a method to provide a data file of Drug Claims in support of MCOs' care coordination and care management activities.
- Establish the process to perform all required inbound and outbound file and/or data transfers and interfaces between the Contractor, MCOs, LDH, and any other entity as required by the Department utilizing a format and transmission method requirement and/or approved by the State.
- Comply with all MCO and LDH required file layouts and data submission standards in accordance with NCPDP D.0.
- Establish the process and frequency for Electronic Funds Transfers (EFT) from the MCOs to the Contractor for weekly reimbursement to pharmacies.
- Establish a process to communicate and coordinate with the MCOs and LDH to meet the needs of Enrollees and Providers (e.g., call center transfers, responding to questions about Drug Claims, addressing complaints, Grievances and Appeals, etc.).
- Establish a process to grant the MCOs, LDH, and other State representatives real-time, unredacted view into the Contractor's Point-of-Sale (POS) Drug Claims processing system, which shall include access to eligibility, Drug Claims, Provider, and payment information.
- Develop and implement necessary transition activities with the MCOs, MCO subcontractors, and LDH.
- Respond to and fulfill all LDH and MCO requests for data, reports, and meetings in the manner and within a timeframe designated by the State.
- Collaborate with MCOs and LDH to enhance Enrollee engagement and education, and measure Enrollee satisfaction.
- Collaborate with LDH and MCOs to assist with items such as care management, population health, medication adherence, and identification of gaps in care.
- Accept a transaction fee for each paid Drug Claim from each MCO in accordance with an LDH-approved methodology as payment in full for services provided under the Contract.
- Receive payments for pharmacy reimbursement directly from the MCOs on a weekly basis.
- Provide a transparent pass-through model of reimbursement. In accordance with La. R.S. 46:450.7, the Contractor is prohibited from facilitating Spread Pricing. The Contractor is also prohibited from applying retrospective clawbacks, true-ups or effective rates without written approval by LDH.

- Perform all functions described herein at no additional cost other than the transaction fee approved by LDH. This includes any modifications or customizations necessary to implement the pharmacy benefit as specified by the Department without exception.
- Disclose all financial terms and arrangements for remuneration of any kind that apply between the MCO, any pharmacy, pharmacy network, pharmacy services organization, prescription drug wholesaler, group purchasing organization, rebate aggregator, manufacturer, labeler, or other drug supply chain intermediaries.
- Not enter into financial agreements that are prohibited by State or Federal law.

The successful Proposer, upon notification of the award, shall ensure connectivity of all information technology systems and to make adjustments to any of the successful Proposer's business operations necessary to implement the services described in this RFP. Within thirty (30) Calendar Days of award, the successful Proposer shall provide an implementation plan that includes all tasks, action steps, timelines, and responsible parties for all requirements contained in this RFP. The successful Proposer shall detail a implementation plan to 1) integrate all Provider, Enrollee, and service data into the Contractor's system; 2) complete all required customizations and requirements listed in the RFP; and 3) account for a testing and Readiness Review phase to ensure all deliverables are met prior to the contract "go-live" date.

As part of the Readiness Review, the Contractor shall:

- Lead User Acceptance Testing to provide an opportunity for LDH and Contractor staff to determine the adequacy of the system's design and functionality in accordance with the requirements and business rules outlined in this RFP.
- Facilitate a presentation to LDH staff where business rules, customizations, and functionality required by this RFP are demonstrated.
- Successfully meet 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.

The Contractor shall collaborate with each MCO to ensure the following prescription billing information is provided on the MCO Member ID card, or on a separate Pharmacy ID Card, or through other technology, that:

- Complies with the standards set forth in the National Council for Prescription Drug Programs (NCPDP) Pharmacy ID Card prescription benefit card implementation guide at the time of issuance of the card or other technology; or
- Includes, at a minimum, the following data elements:
  - The name or identifying trademark of the MCO and the Contractor subject to applicable co-branding restrictions.
  - The name and MCO member identification number of the Enrollee.
  - The telephone number that Providers may call for pharmacy benefit assistance, 24-hour Enrollee services, filing Grievances, Provider services, Prior Authorization, and reporting Fraud.

- All electronic transaction routing information and other numbers required by the Contractor to process a Drug Claim electronically.

2.1.4 Staffing

2.1.4.1 Staffing Requirements

The Contractor shall:

- Enact a staffing strategy that provides for the acquisition, allocation, supervision, and coordination of project staff to ensure that the requirements and service levels in the RFP are met to the satisfaction of LDH.
- Ensure that Key Personnel or their designees are available during Business Hours.
- Make the necessary arrangements to ensure that all Key Personnel are available to meet in person at LDH's headquarter in Baton Rouge when required.
- Provide staff sufficient resources to implement all aspects of the PDL (preferred/non-preferred status, PA requirements, utilization management, DUR edits) into the Drug Claims processing system, as described in *Section 2.1.9 Drug Claim Adjudication System Requirements*.
- 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 PBM Covered Services to any Enrollee.
- 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.
- Ensure 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.
- Ensure personnel who performs work under the Contract have the appropriate license and or certification required by applicable State and Federal laws and/or regulations and the contract.
- Ensure appropriate staff attendance per meeting or event in person or virtual when required.
- Maintain additional sufficient clinical pharmacy and other operational staff necessary to perform the following:
  - Respond to Department and MCOs' needs and inquiries.
  - Conduct research and analysis, upon request.
  - Oversee benefit administration.
  - Ensure the proper reflection of the PDL in the Drug Claims processing system.
  - Support oversight of PA process and have a pharmacist approve the denial of any PA request.

- Conduct reviews of Appeals and Grievances.
- Assist its call center staff with accurate and timely resolution of Provider inquiries.

- Provide the necessary staff, management, and resources to perform mass adjustments to Provider Drug Claims payment history, resulting from retroactive rate changes, policy changes, system Adjudication errors, or other situations as requested by LDH or the MCOs, subject to LDH approval.
- Provide organizational chart:
  - The organizational chart shall be updated as needed to accurately reflect the current staffing levels and depict the Contractor's staff.
  - The organizational chart shall denote all key roles for the provision of services under the Contract.

2.1.4.2 Key Personnel Requirements

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 the contract, and serve in only one key personnel position.

2.1.4.2.1 Chief Operational Officer (COO)

The COO shall:

- Oversee day-to-day business activities.
- Serve as the single point of contact for LDH and the MCOs.
- Be authorized to escalate and resolve issues to meet contract expectations.
- Participate in all State, Provider, or Enrollee meetings as requested by LDH.
- Coordinate maintenance activities with LDH and the MCOs.
- Report on performance measures including Drug Claims processing.
- Coordinate information for and participate in Appeal and Grievance meetings and State Fair Hearings.
- Develop annual work plan including updates from DUR and P&T Committee meetings and present annual work plan outcomes yearly.
- Be accountable for the incorporation of proper payment rates and updates to Drug Claim review procedures, including operations manuals or other such documentation and submit to LDH for approval twice yearly.

The COO shall meet the following minimum qualifications:

- MBA, MHA, MPA, or other advanced business degree or comparable work experience.
- Minimum of three (3) years' experience managing PBM program activities for a state Medicaid program with a population equal or greater than Louisiana Medicaid Program.
- Have demonstrated experience in PBM system operations and experience developing and managing a pharmacy network.

2.1.4.2.2 Clinical Pharmacy Director

The Clinical Pharmacy Director shall:

- Be responsible for all clinical decisions of the Contractor.

- Support the P&T Committee activities.
- Actively support the prospective and retrospective DUR activities.
- Be responsible for recommending benefit design and utilization management improvements to LDH and the MCOs based on data analysis and PBM best practices.

The Clinical Pharmacy Director shall meet the following minimum qualifications:

- Doctorate of Pharmacy degree, be a Louisiana licensed pharmacist in good standing or eligible for licensure in Louisiana.
- Minimum of five (5) years' experience working in a pharmacy practice setting.
- Minimum of three (3) years' experience with a government or private sector health care payer including experience with clinical call centers with a large healthcare payer.

2.1.4.2.3 Information Technology (IT) Manager

The IT Manager shall:

- Oversee information technology and systems to support Contractor operations, including submission of accurate and timely Drug Claims data and business impact analysis of all potential and accepted changes.
- Serve as the primary point of contact for State or MCO technical staff.
- Coordinate with the MCOs' systems and support the development of interfaces.

The IT Manager shall meet the following minimum qualifications:

- Bachelor's degree.
- Three (3) years' experience managing an information technology project of similar or greater scope.

2.1.4.2.4 Point-of-Sale (POS) Programmer

The POS Programmer shall:

- Be responsible for POS programming including, but not limited to configuring existing benefit design, eligibility, DUR, Drug Claim edits, and drug pricing functionality as well as developing enhancements to the POS system as directed by LDH staff.
- Serve as the primary point of contact for POS specifications and edits.
- Understand the MCOs' systems and support the development of interfaces.
- Demonstrate knowledge and experience with NCPDP standards, particularly the Telecommunication, Batch, and Post Adjudicated transactions, and developing Payer Sheets using the NCPDP template.
- Be able to apply HIPAA requirements in a PBM environment.

The POS Programmer shall meet the following minimum qualification:

- Three (3) years' experience POS programming on projects of similar size and complexity.

2.1.4.2.5 Compliance Officer

The Compliance Officer shall:

- Serve as the primary point of contact for all Contractor compliance issues.
- Identify and monitor critical risk areas, initiate risk-mitigation activities and develop action plans.
- Report violations as appropriate or required.
- Identify information protection needs (e.g., HIPAA, privacy regulations).
- Communicate status regarding a plan of action to respond to identified security weaknesses.
- Ensure implementation of effective information protection mechanisms (e.g., data masking, de-identification of data released to non-covered entities, obfuscation when used in non-production environments).

The Compliance Officer shall meet the following minimum qualifications:

- Bachelor's degree.
- Minimum of three (3) years' experience working as a compliance officer for a state Medicaid project of similar or greater scope.
- Certified in Healthcare Compliance (CHC), Healthcare Privacy Compliance (CHPC), Healthcare Research Compliance (CHRC), or Healthcare Compliance-Fellowship (CHC-F).

2.1.4.3 General Staff (excludes key personnel)

General Staff roles shall include:

2.1.4.3.1 Chief Executive Officer (CEO)

The CEO shall:

- Have decision-making authority to commit the organization to the services in *Section 2. Scope of Work.*
- Provide overall direction for the Contractor.
- Develop strategies, formulate policies, and oversee operations to ensure goals are met.
- Be available during LDH working hours to fulfill the responsibilities of the position.

The CEO shall meet the following minimum qualifications:

- Bachelor's degree.
- Minimum of three (3) years' experience managing a program or contract of similar or greater scope with a state Medicaid program.

2.1.4.3.2 Audit Pharmacist

The Audit Pharmacist shall:

- Be a full-time employee (minimum forty (40) hours per week), based in Louisiana, dedicated one hundred percent (100%) to the Contract.
- Be a Louisiana-licensed Pharmacist in good standing or eligible for licensure.
- Be responsible for oversight and implementation of all pharmacy audits and coordination of audit activities with LDH and the MCOs.

- Have no other client responsibilities outside of the Contract.
- Coordinate Drug Claim review activities involving Provider or Enrollee Fraud with the Medicaid Fraud Control Unit (MFCU), law enforcement, LDH and other State and Federal authorities as necessary.
- Ensure recoupment is collected in a timely accurate manner and in accordance with State and Federal requirements.

The Audit Pharmacist shall meet the following minimum qualifications:

- Minimum of two (2) years' experience in the healthcare field working in Fraud, waste, and Abuse (FWA) investigations and audits.

2.1.4.3.3 Financial Manager

The Financial Manager shall:

- Be responsible for accuracy, timeliness, and transparency of Provider payments, remittance advices and financial reports.

2.1.4.3.4 Provider/Enrollee Relations Manager

The Provider/Enrollee Relations Manager shall:

- Be a full-time employee (minimum forty (40) hours per week), based in Louisiana, dedicated one hundred percent (100%) to the Contract.
- Be responsible for all Provider and Enrollee functions including the Call Center.
- Train helpdesk staff to ensure Drug Claim, PA, and encounter inquiries are effectively researched and resolved.
- Escalate matters to LDH when warranted.

The Provider/Enrollee Relation Manager shall meet the minimum qualifications:

- Experience in Medicaid-related policy and standards as well as Drug Claims processing operations.

2.1.4.3.5 Lead Data Analyst

The Lead Data Analyst shall:

- Be a full-time employee (minimum forty (40) hours per week), dedicated one hundred percent (100%) to the Contract.
- Be responsible for coordinating the design and ongoing management of reporting with all stakeholders.
- Travel to Baton Rouge, LA occasionally, upon Department request.
- Be responsible for creating meaningful data presentations.
- Perform predictive modeling and develop trending reports.
- Be responsible for the quality of all data within the system.
- Coordinate with LDH in the planning and execution of data quality initiatives, reporting, and analytics support.
- Create dashboards and reports as requested by LDH.

The Lead Data Analyst shall meet the following minimum qualifications:

- Be a pharmacy data analytics professional.
- Minimum of three (3) years of work experience in data mining and healthcare analytics.

2.1.4.3.6 Fraud, Waste, and Abuse Investigator

The Fraud, Waste, and Abuse Investigator shall:

- Be a full-time employee (minimum forty (40) hours per week), dedicated one hundred percent (100%) to the Contract.
- Be responsible for all FWA activities for the Contractor pursuant to the terms of the Contract.
- Work to detect and prevent FWA and investigate such incidences.
- Coordinate activities with the Audit Pharmacist and MFCU, law enforcement, LDH and other State and Federal authorities as necessary.

The Fraud, Waste, and Abuse Investigator shall meet the following minimum qualifications:

- Have a Bachelor's degree with minimum of two (2) years of experience in the healthcare field working in FWA investigations and audits; or
- Have an Associate's degree, with a minimum of four (4) years of experience working in health care FWA investigations and audits;
- Demonstrated proficiency in understanding and analyzing Drug Claims and coding; and
- Demonstrated knowledge of Provider investigations related to pharmacy and experience working with Program Integrity programs.

2.1.4.3.7 Implementation Manager

The Implementation Manager shall:

- Be responsible for overseeing the implementation of the contract requirements during the implementation phase.
- Possess knowledge of state Medicaid programs, particularly with Medicaid pharmacy benefits, with relevant experience navigating similar complex projects.
- Be located in Baton Rouge, Louisiana at least during the Implementation Phase of the Contract.

2.1.5 Subcontractors

The Contractor shall:

- Not delegate responsibility for Drug Claims processing to another entity.
- Evaluate the prospective Subcontractor's ability to perform the activities to be subcontracted, prior to contracting with a Subcontractor.
- Secure prior written approval of all subcontracts, amendments, and substitutions thereto from LDH.

To obtain such approval, the Contractor shall submit a written request and a copy of the proposed subcontract to LDH. The request shall also describe how the Contractor will oversee the Subcontractor. The Contractor shall provide LDH with any additional information requested by LDH. LDH shall review and approve or deny the subcontract.

Before commencing work, the Contractor will provide letters of agreement, contracts, or other forms of commitment that demonstrate that all requirements pertaining to the Contractor will be satisfied by all Subcontractors through the following:

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

All Subcontracts shall:

- Be written.
- Specify, and require compliance with, all applicable requirements of the Contract and the activities and reporting responsibilities the Subcontractor is obligated to provide.
- Prohibit payment based on commission.
- 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.
- 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.
- 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.
- Require that the State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contract.
    - The Subcontractor will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to Enrollees.
    - This right to audit will exist through ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.
    - If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.
- Comply with 42 CFR §438.3(k).

2.1.6 Covered Populations

The Contractor shall provide PBM Covered Services for all Beneficiaries enrolled in the Managed Care Program for all MCO Covered Services.

2.1.7 Pharmacy and Prescriber Network

The Contractor shall:

- Contract with and manage a robust Network to provide access to PBM Covered Services for Enrollees.
- Develop and implement written policies and procedures for selection and retention of Network Providers that meet the requirements of 42 CFR §438.214. Such policies and procedures, consistent with 42 CFR § 438.12, shall not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.
- Develop and implement written policies and procedures for credentialing and recredentialing Network Providers in accordance with 42 CFR §438.214, La. R.S. 46:460.61applicable Federal and State laws, rules, policies, procedures, manuals, and guidance and the State Plan.
- Not implement any policies or procedures or enter into any agreements that would have the effect of limiting Provider participation in the State.
- Not employ or contract with Providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

2.1.7.1 Provider Agreements

The Contractor shall:

- Develop and utilize a template for Provider Agreements that has been approved by LDH that specifies the requirements for Network Providers and provides for terminating the Provider Agreement or imposing other non-compliance actions and penalties if the Provider's performance is inadequate.
- Not include in its Provider Agreements an all-products clause, requiring Providers to participate in all products offered by the Contractor or its parent organization.
- Inform all Providers, at the time they enter into a Provider Agreement, 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.
- Require that Network Providers not bill Enrollees for PBM Covered Services in any amount greater than assessed copayment.
- The Contractor shall require that Network Providers offer the same services to Enrollees as those offered to individuals not receiving services through the Louisiana Medicaid Program, provided that they are PBM Covered Services. Network 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. Network Providers are not required to accept every Enrollee requesting service.

- The Contractor shall require Network Providers 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.
- The Contractor shall require Network Providers to immediately report cancellation of any required insurance coverage, licensure, or certification to the Contractor.
    - Upon receipt of such report, the Contractor shall immediately notify the Network Provider that it is prohibited from performing any work under the Contract unless and until the Network Provider provides written documentation to the Contractor indicating that the Network Provider has reinstated all required insurance coverage, licensure, or certification.
- The Provider Agreement shall require Network 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 Network Providers to LDH.
- The Contractor shall submit all original and amended Provider Agreement templates to LDH for approval prior to the execution of the agreement with a Provider.
- All Provider Agreements shall provide that the Network 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 the 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 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.
- Inform all Providers, at the time they enter into a Provider Agreement, 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.
- Only include pharmacies in the Network that are enrolled with LDH to provide services under the Louisiana Medicaid Program and conform to the Louisiana Board of Pharmacy rules concerning records to be maintained by a pharmacy.
- Not deny any pharmacy or pharmacist participating in the Louisiana Medicaid Program from contracting as a Provider if 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 Provider Agreement offered to them by the Contractor.

- All Network cancellations shall be approved by LDH at least sixty (60) Calendar Days prior to cancellation unless imminent peril is declared.
- Only reimburse out-of-State pharmacies when the pharmacy is enrolled with LDH to provide services under the Louisiana Medicaid Program and approved by LDH.
- If PBM Covered Services are provided to an Enrollee who is out-of-State, the Contractor shall require the pharmacy to enroll in the Louisiana Medicaid Program for the purposes of securing payment of the Drug Claim and finalizing the Drug Claim at issue, not for obtaining continuous and active Provider status.
- Allow Providers to opt-out of one or more MCO Networks, if desired. For example, if contracted with the Contractor, a pharmacy does not need to be in every MCO Network.
- Educate Providers about how to access the PDL on its website. The Contractor shall also offer Provider education on Drug Claims processing and payment policies and procedures.
- Provide advance written notice to LDH prior to any Provider Agreement termination that causes a Material Change in the Network, whether terminated by the Contractor or the Network 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 Network Providers to prevent stoppage or interruption of services to the Enrollee.
- Provide or arrange for medically necessary PBM Covered Services if the Network becomes temporarily insufficient within a service area.
- Submit required information on Material Changes to its Network in accordance with the MCO Manual in the time period specified by LDH.
- Enter into written Provider Agreements with Providers to provide PBM Covered Services.
- Receive active agreement from pharmacies to participate in an MCO Network within thirty (30) Calendar Days after contracting of the new MCO, in the event of contracting with a new MCO into the Managed Care Program.
    - If a pharmacy is already contracted with the Contractor for other lines of business (commercial or Federal), notification alone shall not be sufficient for that pharmacy to be considered part of the new MCO Network.
    - The pharmacy shall actively agree to the terms of the contract addendum.
- Validate the Prescriber is enrolled in the Louisiana Medicaid Program and registered with the MCO.
- Ensure the Prescriber is eligible to prescribe medications in accordance with the business requirements provided by LDH.
- Ensure the Provider or Prescriber is not excluded by CMS or State entities.
- Capture and utilize the type and specialty of the Prescriber for Drug Claims processing.
- Have the capability of faxing Network Providers and Prescribers and maintain correct facsimile numbers.

2.1.7.2 Pharmacy Provider Directory

The Contractor shall:

- Maintain an up-to-date pharmacy Provider directory for each MCO on its website for public access. Each directory shall include, but not be limited to, the following information for all Providers in the MCO Network:
  - Names, locations, and telephone numbers.
  - Any non-English languages spoken.
  - Identification of hours of operation, including identification of Providers that are open twenty-four (24) hours per day.
  - Identification of Providers that provide vaccine services.
  - Identification of Providers that provide delivery services.
  - Identification of compounding and Specialty Pharmacies.
- Make a hard copy of this directory available to Enrollees upon request at no charge. The online version shall be updated in real time, but no less than weekly.

2.1.7.3 Provider and Enrollee Materials

The Contractor shall:

- Obtain prior written approval from LDH, unless exempted by LDH, for all marketing and Enrollee materials including, but not limited to, websites and social media, ID cards, call scripts for outbound calls or customer service centers, Provider directories, advertisement, and direct Enrollee mailings.
  - Enrollee materials shall be submitted to LDH for approval at least thirty (30) Calendar Days before implementation, unless the MCO and/or Contractor can demonstrate to LDH's satisfaction that just cause for an abbreviated timeframe exists.
- Obtain prior written approval from LDH for all Provider materials related to PBM Covered Services, unless exempted by LDH.
  - Provider (pharmacy and Prescriber) materials shall be submitted to LDH for approval at least thirty (30) Calendar Days before implementation, unless the MCO and/or Contractor can demonstrate to LDH's satisfaction that just cause for an abbreviated timeframe exists.
- Coordinate with the MCO regarding the dissemination of materials to Enrollees and Providers such that the MCO can obtain the appropriate prior approvals from LDH, when necessary.
- Provide Enrollees free access to any Provider participating in the applicable MCO Network (except in cases where the Enrollee is participating in the pharmacy lock-in program) without any form of steering.
- Submit co-branded MCO or Contractor marketing and Enrollee/Provider materials, phone scripts, telemarketing materials, and Enrollee identification cards to LDH for prior approval.
- Not steer Enrollees to certain Providers, including those that are owned by the Contractor or MCO. LDH retains the discretion to deny the use of marketing and Enrollee/Provider material that it deems to promote or suggest undue patient steering.

2.1.7.4 Prohibition of Additional Fees or Charges to Providers

- The Contractor shall not charge fees to Providers for sending, receiving, or processing Drug Claims data; Provider enrollment, credentialing, or recredentialing; or performance of any other requirements under the Contract.
- The Contractor shall not make or allow any direct or indirect reduction of payment to a Network Provider 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, Professional Dispensing Fee effective rates, direct and indirect remuneration fees, chargebacks, or any other reduction or aggregate reduction of payment without written prior written approval from LDH.
- The Contractor shall not implement or apply spread pricing, retrospective claw backs, true-ups or effective rates without written approval by LDH, including, but not limited to group pharmacy organizations or PSAOs.

2.1.8 Pharmacy Reimbursement

2.1.8.1 General Requirements

This Section refers to a collection of business processes and automated functions necessary to support pharmacy payments, record keeping, providing transparency, and the proper management of State and Federal funds used for those payments.

Internal controls and monitoring are important to ensure fiscal integrity and financial management processes are compliant with State and Federal guidance. The Contractor's system shall have the functionality to support the implementation of internal control mechanisms as defined by LDH through timely and accurate financial reports, detailed audit trails, and financial trending.

Reconciliation of all payments, including those that are unsuccessful due to failed electronic fund transfers, shall be performed within a cycle to be defined by LDH. The Contractor shall collaborate with LDH to establish the various cycles and schedules related to disbursement and reconciliation activities.

The Contractor shall:

- Ensure reimbursement to Network Providers is prompt and accurate and in accordance with LDH, State and Federal requirements.
- Not remit payment to any Provider for which the State-issued Medicaid Provider Identifier number has been revoked or terminated by LDH.
- Require at least ninety percent (90%) of the Providers to be reimbursed via an EFT.
- Establish a contract with a national drug database approved by LDH, or other source approved by LDH, to determine payment amounts for the ingredient cost of the drug.
- Perform payment calculations as specified by LDH in a transparent manner and without spread pricing, direct or indirect fees or charges to the Provider, or other methodologies other than those explicitly approved by LDH. Providers shall be compensated using a transparent pass-through method of payment of ingredient cost and any applicable fees paid to the Network Provider.

- Use a uniform reimbursement methodology such that the same pharmacy will be reimbursed the same amount for the same prescription on the same day of service regardless of the Enrollee's MCO.
- Be responsible for payment of PBM Covered Services from an Enrollee's effective date of Enrollment with the MCO.
- Negotiate the Professional Dispensing Fee and ingredient cost reimbursement in contracts with Network Providers to maximize the economy and cost-effectiveness of PBM Covered Services.
- Reimburse Local Pharmacies in accordance with La. R.S. 46:460.36 and the MCO Manual.
- Add the Provider Fee, on top of the Professional Dispensing Fee and ingredient cost reimbursement.
- Update the ingredient costs of medications at least weekly and within three (3) Business Days of new rates being posted from a national database.
- Apply Base Maximum Allowable Cost (MAC) price lists on generic drugs with an FDA interchangeable rating beginning with an "A", if or when a MAC price list is applied to Non-Local Pharmacy Drug Claims.
- Make current and historical drug pricing list available to Network Providers for review at no charge.
- Afford individual Network Providers a chance to Appeal inadequate reimbursement.
- Apply cost sharing (copayment) as follows:
    - Impose cost sharing on Enrollees in accordance with 42 CFR §§447.50 - 447.57, Louisiana Medicaid State Plan, and the MCO Manual. The copay tiers in the State Plan shall be based on the total amount reimbursed to the pharmacy for the Drug Claim.
    - LDH reserves the right to amend cost sharing requirements.
- Reimburse Providers with State Enrollment effective dates equal to or less than ninety (90) Calendar Days prior to execution of the 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 Provider Agreement, reimbursement shall be provided for dates of services on or after the Provider Agreement execution date. In either case, if a Provider would otherwise be eligible for reimbursement at an earlier date under La. R.S. 46:460.62, then reimbursement shall be provided for dates of service on or after that date.
- Manage accounts receivable activities (e.g., reversing of payments due for canceled prescriptions, balancing and offsetting pharmacy reimbursement, and appropriately directing overpayments to LDH-identified entities) and the disbursement of payments to pharmacies on a State-specified schedule.
- Apply, maintain, and store adjustments.
- Support audits of financial activities.
- Provide payments to Network Providers no less than every week and comply with LDH-specified requirements for financial reporting.

- Provide payment by EFT or paper checks as requested by Network Providers and approved by LDH.
- Produce and distribute any applicable tax information related to Network Provider payments and the Federal government (e.g., form Internal Revenue Service (IRS)-1099).
- Support 1099 updates, transmission, and inquiries.
- Capture, maintain, and process unique program and service-related payments.
- Capture and maintain LDH-identified data (e.g., Drug Claim, Enrollee identification, Enrollee enrollment data at time of payable creation, Provider identification, HCPCS codes, dates, amounts, funding sources, reason, approvals, audit information) for all payables.
- Capture recoveries from other state or Federal entities or third-party payers.
- Calculate recoupment amounts, when necessary, as directed by LDH.
- Provide functionality to withhold portions of a payable (e.g., percentage, fixed amount).

The Contractor shall not:

- Deny services to an individual who is eligible for services because of the individual's inability to pay the cost sharing.
- Require Enrollees to use a mail service pharmacy. Mail order shall not exceed more than one percent (1%) of all Drug Claims. Enrollees shall not be charged any amounts above applicable copays for mail order (e.g. shipping and handling fees).
- Restrict Enrollees' access to needed drugs and related pharmaceutical products by requiring that Enrollees use mail-order Network Providers.
- Impose copayments for the following:
  - Family planning services and supplies.
  - Emergency services.
  - U.S. Preventative Services Task Force (USPSTF) A and B Recommendations.
  - Services provided to:
    - Individuals younger than twenty-one (21) years old.
    - Pregnant women.
    - Individuals who are inpatients in long-term care facilities or other institutions.
    - Native Americans.
    - Alaskan Eskimos.
    - Enrollees in a Home and Community Based Waiver.
    - Women whose basis of Louisiana Medicaid Program eligibility is Breast or Cervical Cancer.
    - Enrollees receiving hospice services.

2.1.8.2 Pharmacy Reimbursement Fund Management

Pharmacy Reimbursement Fund Management refers to a collection of business processes and automated functions necessary to support pharmacy payments, provide record keeping transparency, and apply the proper management of State and Federal funds used for those payments.

The Contractor shall not reimburse an affiliated pharmacy more than any other pharmacy on a drug-by-drug basis.

The Contractor's system shall have the functionality to support the implementation of internal control mechanisms as defined by LDH through timely and accurate financial reports, detailed audit trails, and financial trending.

The Contractor shall:

- Have internal controls and monitoring to ensure fiscal integrity and financial management processes are compliant with State and Federal guidance.
- Be responsible for making payments to pharmacies on behalf of the MCOs and be consistent across all MCOs.
- Determine payment amounts using a national drug database approved by LDH indicating the cost of the drugs and a Professional Dispensing Fee that may vary based on the attributes of a given pharmacy:
    - The Provider Fee shall be reimbursed on every Drug Claim when the Louisiana Medicaid Program is the primary payer.
    - The pricing calculation shall be ingredient cost (quantity * price per unit) + Professional Dispensing Fee – Third Party Liability (TPL) paid – copayment + Provider Fee = payment. If the Usual and Customary (U&C) Charge is less than the MAC, then the calculation is U&C Charge – applicable TPL amount paid – copayment + Provider Fee = payment. MAC is defined as Professional Dispensing Fee plus ingredient cost (quantity * price per unit) or U&C Charge, whichever is less.
- Perform reconciliation for all payments, including those that are unsuccessful due to failed electronic fund transfers, within a cycle to be defined by LDH.
- Collaborate with LDH to establish the various cycles and schedules related to disbursement and reconciliation activities.

2.1.8.3 Pharmacy Remittance Advices

The Contractor shall:

- Provide remittance advices to Network Providers electronically and as specified by LDH.
- Provide remittance advices to Network Providers that comply with the provisions of La. R.S. 46:460.71, the MCO Manual, and 42 CFR §455.18 and §455.19.
- Provide adjustments and voids on the remittance advice under "Adjusted or Voided Claims" either as Approved or Denied.
- Submit a sample of remittance advices that were sent to Local, Non-Local and Specialty Pharmacies by the Contractor to LDH pharmacy staff quarterly. This sample shall include at least ten (10) remittance advices from different pharmacies from each pharmacy type (Local, Non-Local, and Specialty). Each quarter shall have samples from different pharmacies.
- Base its electronic remittance advices transmissions on HIPAA-mandated transactions and utilize code sets in compliance with HIPAA rules.

- Implement the updated HIPAA transaction sets as updates become available and are mandated at no additional cost to the MCOs.
- Maintain compatibility with pharmacies using the previous version elements and those pharmacies using the updated version(s), according to the timeline approved by LDH.
- Provide all data elements required by LDH.
- Provide a standalone RA, specific to the Louisiana Medicaid Program and separate from other lines of business at the request of the pharmacy.
- Provide a portal to allow pharmacies to check all payments at an individual Drug Claim level, which includes the methodology by which the Drug Claim paid.
- Pay ninety percent (90%) of all Drug Claims within fifteen (15) Calendar Days and one hundred percent (100%) within thirty (30) Calendar Days from submission of the Drug Claim.
- Pay Network Providers interest at a rate of twelve percent (12%) per annum, calculated daily for the full period in which a payable Drug Claim remains unpaid beyond the thirty (30) Calendar Day Drug Claims processing deadline. Interest owed to the Network Provider shall be paid the same date that the Drug 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.

2.1.8.4 Pharmacy Claims Dispute

The Contractor shall:

- Maintain an internal Drug Claims dispute process to permit Network Providers to dispute the reimbursement paid for any Drug Claim.
- Permit Network Providers to submit Drug Claim disputes directly to the Contractor or through a Pharmacy Services Administrative Organization (PSAO) at the Network Provider's option.
- Provide written notification of the outcome of the internal Drug Claims dispute process to the Network Provider, LDH and the MCO within seven (7) Business Days of the date that the dispute was received by the Contractor with the following requirements:
  - LDH has the authority to overturn the Contractor’s decision on internal Drug Claims’ disputes.
  - If LDH disagrees with the Contractor’s decision, LDH shall provide written notification of its decision within seven (7) Business Days of the receipt of the Contractor’s decision.
  - LDH’s decision shall be considered final.

The Contractor may require Network Providers to submit Drug Claim disputes within a predetermined time limit. Such limit shall be no less than seven (7) Business Days after the Drug Claim fill date.

2.1.9 Drug Claim Adjudication System Requirements

2.1.9.1 General Drug Claim Adjudication System Requirements

The Contractor’s Drug Claim Adjudication system shall:

- Adhere to all State and Federal accessibility requirements, or their successors.
- 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].
- Comply with the latest version of the W3C Mobile Web Application Best Practices for browser-based components.
- Comply with the current Authoring Tool Accessibility Guidelines (ATAG) as published by the Worldwide Web Consortium (W3C).
- Perform balancing procedures to guarantee control within the Drug Claims processing cycles including, but not limited to, ensuring that each Drug Claim received by the system is properly included in all payments, data extracts, or reports in which it shall be included.
- Collaborate with LDH to develop, implement, and maintain payer sheet(s) using the NCPDP-published template and following the guidance it contains.
- Impose different copays for groups of Enrollees based on the Enrollee's copay code.
- Recognize all applicable copays or coinsurance and deduct that amount from the payment made to the Network Provider.
- Report copay, coinsurance, and deductible information to LDH as required by LDH.
- Calculate different copayment amounts or exempt copay based on pharmacy services, populations, variations in programs, products, Enrollee age, eligibility attributes, Provider groups, categories of service and Drug Claim data elements.
- Ensure cost sharing does not exceed five percent (5%) of the household's monthly income.
- Provide functionality for LDH-authorized users to export and print selected Drug Claim information into a standardized human readable format (e.g., 1500, UB04 claim forms), including all associated data and attachments used in the Adjudication.
- Accept and capture Drug Claim attachments, Drug Claim notes, and supporting information as directed by LDH.
- Assign a unique tracking number to all Drug Claim attachments, Drug Claim notes, and supporting information.
- Associate and maintain all Drug Claim attachments, Drug Claim notes, and supporting information to the original Drug Claim and associated applicable transaction for an LDH-defined time in accordance with State and Federal requirements.
- Establish a Louisiana Medicaid specific Bank Identification Number (BIN)/Issuer Identification Number (IIN), Processor Control Number (PCN), and Group Number combination for POS Drug Claims processing.
    - These numbers shall uniquely identify each MCO and ensure Louisiana Medicaid Program Drug Claims are distinguishable from the Contractor's commercial, Medicare Part D and other business lines.
    - The BIN/IIN, PCN and group number shall appear on all Enrollees' identification cards along with the toll-free phone number for Provider and Enrollee assistance.

- Work with LDH and other vendors, as necessary, to establish appropriate system interfaces. The Contractor shall:
  - Accept and conform to the interface layouts currently in use by LDH and its vendors unless otherwise approved by LDH.
  - Establish file transfers as necessary to determine Enrollee and Prescriber eligibility and TPL information.
  - Provide daily Drug Claims and payment history files directly to the MCO.
  - Maintain a comprehensive data dictionary and make the dictionary available to the MCOs and LDH.
  - Ensure data and reference files accessed for Adjudication are accurate and maintained timely.
- Integrate historical Drug Claims data provided by each of the MCOs. This includes a minimum of twenty-four (24) months of Drug Claims history, open PAs, and other patient-specific data to be available for PA automation during Adjudication.
- Maintain a minimum of twenty-four (24) months of data in the POS system after a MCO leaves the program.
- Honor existing PAs issued by the MCOs or their PBM through the PA end date included on the historical PA file provided by each MCO, unless otherwise directed by LDH. At the direction of LDH, grandfather patients with specified prior drug history (with or without a PA on file) to permit Adjudication without a PA denial.
- Provide a mechanism for LDH and the MCOs to view unredacted Adjudicated Drug Claims, PA records, and reference files in a real-time environment.
- Perform a risk assessment of the Drug Claims processing system and Drug Claim operations business processes on an annual basis and provide a written report including the methodology to conduct the assessment, findings, and planned action(s) to mitigate identified risk(s) and address identified issues.
- Utilize the Louisiana Medicaid Identification Number and aggregate Enrollee history across multiple eligibility spans, if applicable.
- Apply individual Prescriber or Network Provider-related restrictions such as special Drug Claim reviews, payment withholds, including withholds for delinquent taxes, or other limitations as instructed by LDH.
- Update ingredient cost rates within three (3) Business Days of new rates being posted from a nationally recognized database approved for use by LDH.
- Require Network Providers to file Louisiana Medicaid Program-only Drug Claims within three hundred sixty-five (365) Calendar Days of the DOS.
- Allow Network Providers to back bill electronically (reversals and resubmissions) not to exceed three hundred sixty-five (365) Calendar Days back to the DOS.
- Require Network Providers to file Drug Claims involving TPL (excluding Medicare) within three hundred sixty-five (365) Calendar Days from the DOS.
- Require Network Providers to file the Drug Claim within one hundred eighty (180) Calendar Days from Medicare's EOB of payment or denial when Medicare is the primary insurer.
- LDH will identify and address any exceptions to these provisions in the MCO Manual.

- Support interfaces with Network Provider point-of-sale systems (and their facilitating networks) and Prescriber's electronic health record (EHR) systems, providing seamless interoperability through the life cycle of a prescription.

2.1.9.2 General Drug Claim Processing Requirements

The Contractor shall:

- Conduct Drug Claims processing consistently across all MCOs that prevents duplication of effort or multiple solutions and allows changes to be made easily and seamlessly for the entire Managed Care Program.
- Receive, Adjudicate, and correctly price one hundred percent (100%) of Drug Claims, including Drug Claims for multi-ingredient compounded prescriptions, whether submitted electronically or on paper.
- Be able to accept multiple concurrent electronic Drug Claims transactions while maintaining required maximum processing times and minimum uptimes.
- Maintain permanent history by service date for those services identified as "once-in-a-lifetime".
- Not utilize a Subcontractor for Drug Claims processing.
- Have an automated Drug Claims processing system for Drug Claims that support the requirements of the contract and ensures the accurate and timely processing of Drug Claims and encounters.
- Comply with State and Federal requirements on the proper use of current standards, recognition, and enforcement of Third-Party Liability (TPL) and coordination of benefits (COB), adjusting prior Adjudication, and efficient handling of paper records when necessary.
- Apply Drug Claim edits to include, but not limited to, eligibility, drug coverage, benefit limitations, Network Provider, Prescriber and prospective/concurrent drug utilization review edits.
- Make all program changes as directed by LDH with a formal process for changes such as a Benefit Change Form (BCF). The BCF shall be completed and executed by both LDH and the Contractor to make modifications to the benefit plan design. The Contractor shall be responsible for maintaining a file of all BCFs for LDH and provide LDH with said BCFs upon request for review or audit purposes.
- Process and reimburse Drug Claims without inappropriate denials, delays, or recoupments.
    - If the Contractor has a pattern, as determined by the MCO, of inappropriately denying, delaying or recouping Provider payments for services, the Contractor may be subject to Monetary Penalties equal to one and one-half (1.5) times the value of the Drug Claims inappropriately denied, delayed, or recouped, contract cancellation, or refusal to contract in a future time period.
    - If the Contractor has a pattern, as determined by the MCO, of inappropriately denying, delaying, or recouping Provider payments for services after the termination of the Contract, the Contractor may be subject Monetary Penalties equal to one and

one-half (1.5) times the value of the Drug Claims inappropriately denied, delayed, or recouped.

- Retain historical data submissions for a period not less than ten (10) years, following generally accepted retention guidelines.
- Maintain audit trails online for no less than six (6) years.
- Retain additional history for no less than ten (10) years.
- Provide a maximum forty-eight (48) hour turnaround on requests for access to information that is between six (6) to ten (10) years old in machine readable form.
- Ensure that National Drug Code (NDC), which includes the manufacturer number, product number and package number for the drug dispensed is listed on all Drug Claims and encounters. This information shall be taken from the actual package from the dispensed drug.

2.1.9.3 Drug Claims System Requirements

The Contractor's system shall:

- Support electronic submission of Drug Claims using the most current HIPAA compliant transaction standard (Currently NCPDP D.0).
- Provide information on areas including, but not limited to, utilization, Drug Claims, Grievances and Appeals, and Disenrollment for reasons other than loss of Louisiana Medicaid Program eligibility [42 CFR §438.242(a)].
- Provide for an automated update to the National Drug Code file including all product, packaging, prescription and pricing information.
- Provide public online access to reference file information (e.g. drug name, NDC, unit price(s), payable status, manufacturer, therapeutic class, etc.) for the MCOs, LDH, and representatives of the State.
- Be responsible for procuring and maintaining hardware and software resources which are sufficient to successfully perform the services detailed in the Contract.
- Maintain a history of the pricing schedules and other significant reference data.
- Update the drug file, including price, within three (3) Business Days of receipt of changes, notification from a national data base, or LDH.
- Have the capability to implement pharmacy value-based payment incentives meant to improve health outcomes.
- Implement a single solution that interfaces with each MCO.
- Not maintain separate Drug Claims processing systems for each MCO nor alter or customize its Drug Claims processing for each MCO, ensuring Drug Claims processing shall occur as specified by LDH without exception and be uniform for all MCOs.
- Interoperate as needed with LDH's systems and shall conform to applicable standards and specifications set by LDH including all Contractor applications, operating software, middleware, and networking hardware and software.
- Be capable of adding, changing, or removing Adjudication rules, edits, pricing, product status and all Adjudication elements to accommodate LDH-required changes.

- Completely Adjudicate Drug Claims with a maximum response time of no longer than one (1) second, ninety-eight percent (98%) of the time measured weekly and reported monthly. Response time means the time from when the Drug Claim is received by the Contractor until the time the results are transmitted from the Contractor and includes all procedures required to complete the Adjudication.
- Conduct research on Drug Claim payment problems and provide a root cause analysis (RCA).

- Be responsible for all expenses required to obtain access to LDH systems—including systems maintained by other Contractors including, but not limited to, FI and Enrollment Broker resources that are relevant to successful completion of the requirements of the Contract, unless explicitly stated to the contrary. 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 the Contract. Such expenses are inclusive of hardware, software, network infrastructure and any licensing costs.
- Alert LDH of outstanding Drug Claim payment issues and resolve within 24 hours unless LDH approved an extension in writing.
- 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.
- Implement PDL change notices as needed.
- Not revise or modify standardized forms or formats.
- Interface with LDH, the FI, the Enrollment Broker, and other State contractors. 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.
- Maintain hardware and software compatible with current LDH requirements in accordance with the MCO Manual.
- Have network and back-up capabilities in accordance with the MCO Manual.
- Ensure Medicare Part B products covered by the Louisiana Medicaid Program for the dual eligible are paid only after Medicare is billed as the primary payer at least quarterly or otherwise specified by LDH.
- Track drug utilization and denied PAs.
- 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:
    - Major changes, upgrades, modification or updates to application or operating software associated with the following core production systems:
        - Drug Claims processing.
        - Eligibility and Enrollment processing.
        - Service authorization management.
        - Provider Enrollment and data management.

        - Conversions of core transaction management systems.
    - Respond to LDH notification of system problems not resulting in system unavailability according to the following timeframes:
        - Within five (5) Calendar Days of receiving notification from LDH, the Contractor shall respond in writing to notices of system problems.
        - Within fifteen (15) Calendar Days, the correction shall be made or a requirements analysis and specifications document will be due.
    - Correct each deficiency by an effective date to be determined by LDH.
    - Have a system-inherent mechanism for recording any change in the Contractor's systems to a software module or subsystem.
    - Put in place procedures and measures for safeguarding against unauthorized modification to the Contractor's systems.
    - Not schedule systems unavailability to perform system maintenance, repair and/or upgrade activities during hours that can compromise or prevent critical business operations, unless otherwise agreed to in advance by LDH.
    - 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.
    - Receive, process and update Enrollment files sent by the Enrollment Broker, and update eligibility and Enrollment databases within the following timelines:
        - Daily files – within twenty-four (24) hours of receipt.
        - Weekly reconciliation files – within three (3) Business Days of receipt.
        - Quarterly or monthly reconciliation files – within five (5) Business Days of receipt.
        - Special corrections files – within seven (7) Business Days of receipt.
    - Be capable of uniquely identifying (i.e., Master Patient Index) a distinct Enrollee across multiple populations and systems within its span of control.
    - Receive a list of Louisiana Medicaid Program Provider types, specialty, and sub-specialty codes provided by LDH or its designee. The Contractor shall provide the following:
        - A weekly Pharmacy Provider Network File.
        - Performance of all Federal or State mandated exclusion background checks on all Network Providers, including owners and managers. The Network Providers shall perform the same for all their employees at least annually.

The Contractor may be required to implement medication synchronization; a service that synchronizes the filling or refilling of prescriptions in a manner that allows the dispensed drugs to be obtained on the same date each month.

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.

2.1.9.4 Information Systems Availability

The Contractor shall:

- Not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the Contractor's span of control.
- 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.
- Provide access to the following systems, including systems owned and/or operated by Subcontractors (this is not an exclusive list):
    - Prior Authorization.
    - Drug Claims processing.
    - Provider portal.
    - Third Party Liability.
    - Fraud, Waste, and Abuse.
    - Point of Sale.
    - Provider contracting and credentialing.
- 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 the Contract, including, but not limited to, the Contractor's obligation to provide information at the request of LDH.
- 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.
- 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.
- Ensure that, at a minimum, all other system functions and information are available to the applicable system users from 7:00 a.m. to 7:00 p.m., Central Time, Monday through Friday.
- Ensure that the systems and processes within its span of control associated with its data exchanges with the FI and/or Enrollment Broker and its contractors are available and operational.
- 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 Drug Claims processing system shall be back on line within seventy-two (72) hours of the failure's or disaster's occurrence.

- Unless otherwise specified herein, 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, LDH's 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.
- 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.
- 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.
- 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.
- 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.
- 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.

2.1.9.5 Off Site Storage and Remote Back-up

The Contractor shall develop and implement data back-up policy and procedures that provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.

The data back-up policy and procedures shall include, but not be limited to:

- Descriptions of the controls for back-up processing, including how frequently back-ups occur.
- Documented back-up procedures.
- The location of data that has been backed up (off-site and on-site, as applicable).
- Identification and description of what is being backed up as part of the back-up plan.
- Any change in back-up procedures in relation to the Contractor's technology changes.
- A list of all back-up files to be stored at remote locations and the frequency with which these files are updated.

2.1.9.6 Records Retention

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 Drug Claims shall remain in the current/active Drug Claims history that is used in Drug Claims editing and are not to be archived or purged. Online access to Drug Claims processing data shall be by the Medicaid Beneficiary ID, Provider ID, Provider NPI, and/or ICN (internal control number) to include pertinent Drug Claims data and Drug Claims status.
- Audit trails shall be maintained online for no less than six (6) years following termination of the Contract.
- 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.
- 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.
- Under no circumstances shall the Contractor destroy or dispose of any such records, even after the expiration of the retention periods provided above, without the express prior written permission of LDH.

2.1.9.7 Information Security and Access Management

The Contractor's system shall:

- Employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:
  - Establish unique access identification per Contractor employee.
  - Restrict access to information on a "least privilege" basis, such as users permitted inquiry privileges only shall not be permitted to modify information.
  - 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.
  - Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.
- 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.
- 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.

- 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:
  - 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.
  - Have the date and identification "stamp" displayed on any online inquiry.
  - Have the ability to trace data from the final place of recording back to its source data file and/or document.
  - Be supported by listings, transaction reports, update reports, transaction logs, or error logs.
  - Facilitate auditing of individual records as well as batch audits.
- Have inherent functionality that prevents the alteration of finalized records.
- 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.
- 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.
- 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.
- 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.
- Ensure that remote access users of its systems can only access said systems through two-factor user authentication and via methods such as Virtual Private Network (VPN), which must be prior approved by LDH in writing as part of Readiness Review.
- 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.
- Ensure appropriate protections of shared Personally Identifiable Information ("PII"), in accordance with 45 CFR §155.260.
- Ensure that its system is operated in compliance with the CMS' latest version of the Minimum Acceptable Risk Standards for Exchanges (MARS-E) Document Suite, currently MARS-E version 2.0.
  - 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.

- 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.

2.1.9.8 Drug Claims Submission to the MCOs

To comply with Drug Claims submission requirements, the Contractor shall:

- Submit a daily file of all Adjudicated Drug Claims to the MCOs which includes individual Drug Claim-level detail information, including but not limited to the total number of metric units, dosage form, strength and package size, and National Drug Code (NDC) of each covered outpatient drug. (Refer to the MCO Systems Companion Guide or the Louisiana Medicaid Management Information Systems (LA MMIS) Batch Pharmacy Encounters Companion Guide for a complete listing of Drug Claim fields requirements).
- Receive data (e.g., recent diagnosis information) from MCOs necessary to ensure the Contractor's records are complete and up to date, using a data exchange method, schedule, and format agreed to by LDH.
- Investigate any questionable Drug Claims or encounters.
- Support the MCOs with disputed encounter files by allowing the MCO, if needed, to correct, and resubmit any disputed encounters.
- Send a disputed encounter response file for rebate purposes that includes:
  - Corrected and resubmitted encounters as described in the Rebate Section of the MCO Systems Companion Guide, and/or
  - 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/Drug Claim-level detail, as described in the Rebate Section of the MCO Systems Companion Guide or the Louisiana Medicaid Management Information Systems (LA MMIS) Batch Pharmacy Encounters Companion Guide.

At least quarterly, LDH may review the MCO's pharmacy encounters for rebate purposes and send a file back to the MCO of disputed encounters that were identified through the drug rebate invoicing process.

2.1.9.9 EDI (Electronic Data Interchange) X-12 Claim Submissions

The Contractor shall:

- Ensure that the hardware, software, and infrastructure related to Drug Claim processing meets the requirements of LDH.
- Utilize the necessary hardware, software, and infrastructure to manage transactions.

- Encourage Network Providers to submit and receive Drug Claims information through electronic data interchange (EDI) as an alternative to the filing of paper-based Drug Claims.
- Facilitate the return of properly formatted responses during any system outage of either a planned or unplanned nature to advise the submitter of the estimated time that the system shall be available to process Drug Claims requests.
- Provide implementation and ongoing support of Network Provider interaction with the Drug Claims processing system including, but not limited to:
  - Establishing Provider testing procedures acceptable to LDH.
  - Developing and delivering Provider training proactively and to address improper submissions.
  - Coordinating with switch and software vendors to ensure smooth operation of the Drug Claims processing system.
- Provide trading partner testing and trouble resolution assistance at no additional cost to the trading partner or LDH.
- Report and provide testing results information about test transactions to the submitter.
- Provide additional FAQs and other training content related to this business process monthly, or as directed and approved by LDH.

2.1.9.10 Mandatory Generic Substitution

There shall be a mandatory generic substitution for all drugs, when a generic is available, unless the brand is justified with applicable dispense as written (DAW) codes, or the brand is preferred on the PDL. Drugs shall be designated as brand or generic by LDH.

The Contractor shall:

- Prohibit the therapeutic substitution of a prescribed drug without a Prescriber's authorization, except for the use of approved generic drug substitution of brand drugs.
- Allow the following DAW codes:
  - DAW 0 (No product selection indicated): for generic drugs.
  - DAW 1 (Substitution not allowed by Prescriber): allow brand to pay at brand price when the Prescriber indicates brand name is medically necessary.
  - DAW 5 (Substitution allowed - brand drug dispensed as a generic): only allow for 340B Providers when the brand is less expensive than the generic.
  - DAW 8 (Substitution allowed - generic drug not available in marketplace): allow brand to pay at brand price when generic shortage has been confirmed by LDH.
  - DAW 9 (Substitution allowed by Prescriber but the brand is preferred product): allow the brand to pay at the brand price when the brand is preferred, and generic is non-preferred.

2.1.9.11 340B Drug Pricing Program

The overlap of the 340B Drug Pricing Program and the Medicaid Drug Rebate program creates the possibility of duplicate discounts. States are Federally mandated by 42 USC §1396b(m)(2)(A) to seek drug rebates on managed care Drug Claims, meaning that the potential for duplicate discounts exists for managed care Drug Claims. Louisiana uses the Health Resources and

Services Administration's (HRSA) Medicaid Exclusion File (MEF) for both Fee for Service (FFS) and Managed Care Program Drug Claims to prevent duplicate discounts. LDH shall provide a quarterly 340B Provider list to the Contractor for Drug Claims editing.

The Contractor shall:

- Require that Network Providers, who are covered entities, as defined by Section 340B of the Public Health Services Act, utilize the same carve-in or carve-out designation for all Enrollees. If a covered entity appears on the Medicaid Exclusion File, LDH shall exclude that Provider's Drug Claims from rebate invoicing.
- Not allow Network Providers to bill the Louisiana Medicaid Program for drugs purchased at 340B pricing.
- Include billing instructions on how to identify 340B Drug Claims/encounters in their contracts with 340B Network Providers.
- Establish and maintain Drug Claims processing capability to appropriately identify, process, and pay any Drug Claim for a drug discounted under the 340B drug pricing program.
- Ensure that Drug Claims paid after applying 340B pricing rules are identified as such, for purposes of withholding the Drug Claim from inclusion in rebate programs, in accordance with the following:
    - Carve-In Drug Claims: On 340B Drug Claims, a value of "20" in NCPDP field 420-DK (Submission Clarification Code) and a value of "8" in NCPDP field 423-DN (Basis of Cost Determination) shall be submitted in the Drug Claim segment of a billing transaction. If a Network Provider is on the 340B Provider list from LDH, all Drug Claims shall have a Drug Claim-level indicator, or the Drug Claim shall be denied.
    - Professional Services Drug Claims (Physician-Administered Drug Claims): Physician-Administered Drug Claims shall use the UD modifier to identify 340B drugs on outpatient physician-administered Drug Claims.
    - Carve-Out Drug Claims: Covered entities who carve out Enrollees shall bill according to guidelines provided in each MCO's Provider manual.

2.1.9.12 Hepatitis C Direct-Acting Antivirals

The Contractor shall program denials of 340B Drug Claims for all Hepatitis C direct acting anti-viral (DAA) agents. The denials shall be based on the 340B Provider list provided by LDH quarterly or Drug Claim level indicators as directed by LDH.

2.1.9.13 Utilization Management

The Contractor shall implement, operationalize, and continuously maintain systems and edits to properly administer all utilization management functions including, but not limited to, the following:

- Facilitate requirements analysis documentation meetings and draft a Requirements Analysis Document (RAD) subject to LDH's approval.
- Accurately administer the pharmacy benefit design, including the PDL, PA, and other utilization edits and audits as defined and periodically updated by LDH.

- Accommodate changes in POS benefit design, Drug Claim edits and audits, and POS messaging to pharmacies.
- Develop and maintain the Adjudication system to accurately implement the PDL, including supporting edits related to the PDL, sending POS messaging through the online real-time Adjudication system, advising of preferred drug products for Brand preferred over generic products and the PA status.
- Submit all Adjudicated Drug Claims to MCO daily. The Contractor shall use the format required by LDH and accommodate changes to encounter data edits within thirty (30) Business Days of receipt or the LDH effective date, whichever is later.
- Ensure the ability of the electronic Drug Claims processing system to indicate when a PA is needed, and as directed, perform automated/electronic PA evaluation, which may include electronic step therapy and consideration of ICD-10 code(s) or other medical claims information submitted by the pharmacy during the POS transaction that integrates with electronic prescribing (ePrescribing) or supplied by LDH or a LDH contractor through a file exchange process established with the Contractor.
- Review edits on an ongoing basis, minimally quarterly, to identify and present opportunities to the MCOs and LDH for consideration that may lessen Provider administrative burden without compromising the administration of PBM Covered Services and corresponding rules.
- Provide data (e.g., Drug Claims, Pharmacy PA requests) to MCOs, the State, and its representatives necessary to support care management of Enrollees and other Medicaid-related business processes using a data exchange method, schedule, and format agreed to by LDH.
- Receive data (e.g., recent diagnosis info) from MCOs necessary to ensure the Contractor's records are complete and up to date using a data exchange method, schedule, and format agreed to by LDH.
- Maintain Enrollee histories for purposes such as performing clinical edits, PA step therapy, ProDUR screening of submitted Drug Claims, and Retro DUR activities.
- Ensure all edits and audits are working correctly and are maintained to meet LDH's requirements.
- Ensure POS messaging can be modified quickly and efficiently.
- Maintain robust edits, including Morphine Milligram Equivalents (MME) accumulated over time and across Drug Claims and product groupings, and other POS utilization methodologies to drive appropriate utilization of opioids and other controlled substances.
- Conduct a PA program that complies with requirements identified in Section 2.1.10.2 *Prior Authorization*.
- Accommodate and support an LDH approved and directed Lock-In program to address utilization management issues and to support MCO care coordination activities. The Lock-In program shall allow up to four Prescriber fields and two pharmacy fields.
- Provide the capability to develop and maintain an NDC to HCPCS crosswalk including unit conversions upon implementation by LDH.

- Provide the capability to produce an extract file of procedure code drug pricing to be shared and utilized by other stakeholders processing Drug Claims for Provider administered pharmaceuticals upon implementation by LDH.
- Configure and continuously maintain detailed electronic documentation of its systems and processes to properly administer all aspects of LDH's Drug Claim processing requirements, including, but not limited to the following:
    - Capture all data submitted on the form with the Enrollee eligibility group/benefit plan under which the Drug Claim was processed.
    - Record with each Drug Claim the Enrollee's enrollment by MCO, as may apply, under which the Drug Claim was processed.
    - Capture all Drug Claim submissions, regardless of the disposition of the Drug Claim.
- Comply with all State and Federal requirements for reimbursement of Medicaid Prescription Drugs under the Deficit Reduction Act (DRA), ACA, and all other applicable State and Federal laws, regulations, rules, policies, procedures, manuals, and guidance.
- Supply a Point-of-Sale (POS) system that is compliant with the most current version of all applicable National Council for Prescription Drug Program (NCPDP) requirements, formats, and standards that are mandated under the Health Insurance Portability and Accountability Act (HIPAA).
- Be responsible for all costs and efforts related to completing any NCPDP or HIPAA adopted updates to transaction sets to ensure continued compliance with existing NCPDP or HIPAA transaction and code set regulations.
- Provide Drug Claim and eligibility processing services that are compliant with current and future HIPAA-adopted Transactions and Code Sets standards, including, but not limited to:
    - International classification of diseases (ICD) codes, most current version.
    - Healthcare Common Procedure Coding System (HCPCS) codes.
- Work with LDH, Providers, contracted MCOs, and other stakeholders to maintain a Drug Claims processing environment that meets the current and future needs of these stakeholders to comply with HIPAA and any other applicable new and revised rules that may be adopted by CMS and other Federal partners.
- Adhere to all State technical requirements unless otherwise instructed or permitted by LDH.
- Manage Adjudication, which includes receipt, data validations, pricing, and response within expected time parameters.
- Date and time stamp all paid Drug Claims when the Drug Claim was Adjudicated for audit purposes.
- Track and report on the specific Adjudication rule in effect by date of service (DOS) and date of payment, and the date the rule was changed, added, or deleted.
- Adjudicate all Drug Claims, maintaining documentation for all Drug Claims administration, including, but not limited to, all materials being keyed or scanned and uploaded so that an official record is stored and retrievable in electronic format.

- Provide tools that support visibility to and management of the configuration of pricing rules, validations performed, and other required edits.
- Comply with State and Federal requirements associated with the proper use of transaction standards in data exchanges with all stakeholders.
- Perform and maintain high-quality records associated with any adjustments to prior Adjudication, should they be required.
- Adjudicate and report on all Drug Claims and Network Provider payments in accordance with LDH-defined program policy, established reimbursement minimum fee schedules, State and Federal statutes and regulations, and HIPAA.
- Establish Adjudication rules customized for each LDH program by category codes, eligibility status, Enrollee attributes (e.g., age, medical condition), drug or drug class (e.g., brand/generic status, drug coverage status, PDL status), Medicare-Medicaid dual eligible status and other criteria specified by LDH.
- Utilize pricing rules and algorithms as directed by LDH.
- Maintain on the Drug Claim record for each paid Drug Claim what methodology (e.g., MAC, National Average Drug Acquisition Cost (NADAC), submitted U&C Charge) was used to determine final payment amount.
- Have the ability to accept Drug Claims and process where the U&C Charge equals $0.00.
- Create mass adjustment events in response to retroactive changes in data used for Drug Claim processing (e.g., product pricing, Professional Dispensing Fee rates, policy, eligibility determination) at the direction of LDH.
- Produce the requested mass adjustment report or data set containing all Drug Claims to be adjusted and the potential payment/recoupment amount both at a Drug Claim and summary level. All mass adjustments shall be approved by LDH before being performed in a production environment.
- Collaborate with LDH to identify the parameters necessary to select Drug Claims for a mass adjustment.
- Enter mass adjustment parameters when directed by LDH and assign a unique tracking number to all Drug Claim adjustments.
- Release mass adjustment for payment and recoupments within one (1) Business Day of receiving approval from LDH.
- Transfer one hundred percent (100%) of its recoupments the appropriate MCO.

2.1.9.14 POS Adjudication

The Contractor shall ensure the POS system meets the following Adjudication requirements.

2.1.9.14.1 Enrollee Eligibility

The system shall:

- Validate Enrollee eligibility via a HIPAA standard eligibility request transaction, such as the X12N 270/271 transaction set, or as directed by LDH.
- Integrate the eligibility file daily.

- Impose pharmacy benefits restrictions that apply to a given Enrollee, living arrangements or place of service (e.g., ambulatory versus long-term care settings), or program enrollment.
- Verify that all Enrollees for whom Drug Claims are submitted qualify to receive pharmacy benefits through LDH's outpatient pharmacy program. This verification shall substantiate that the Enrollee:
  - Was enrolled in the Louisiana Medicaid Program and the MCO on the DOS for the PBM Covered Service.
  - Is entitled to receive the requested PBM Covered Service.
  - Does not have any other benefit design or individual restrictions or conditions that would preclude or affect payment.
  - Has been assessed for other insurance coverage, and LDH's TPL rules and requirements are met during Adjudication.

2.1.9.14.2 Covered Drugs

The Contractor shall:

- Utilize a system that verifies that the NDC is valid, and the drug is eligible for payment under LDHs' pharmacy program and eligible for Medicaid drug rebates, unless otherwise directed by LDH.
- Properly identify all Specialty Drugs by HCPCS, NDC, or alternative drug classification code and coordinate with other Drug Claims processing stakeholders to assure that these Drug Claims are appropriately routed for processing.
- Allow for the capability for maximum dollar thresholds to be set for a specific group or groups of drugs, using any level of drug classification including, but not limited to, full or partial NDC matching, generic product identifiers, or high-level therapeutic class.
- Comply with the maximum dollar thresholds as established by LDH prior to go-live.
- Provide flexibility so that the maximum dollar threshold for single drug Drug Claims and Drug Claims for multi-ingredient compounds could be different, can be overridden, and that certain drugs (defined by any standard criteria) can be excluded from a threshold.

2.1.9.14.3 Prescriber Enrollment

The Contractor shall:

- Validate that the Prescriber is currently enrolled with LDH to provide services under the Louisiana Medicaid Program.
- Validate that the Prescriber has a current agreement with the MCO to provide services under the Louisiana Medicaid Program to the MCO's Enrollees.
- Ensure the Prescriber is eligible to prescribe medications in accordance with the business requirements provided to the Contractor by LDH.
- Deny Drug Claims from Prescribers whose license to practice has been restricted or revoked by the responsible licensing board or other regulatory agencies of authority (e.g., Drug Enforcement Agency).
- Update the list of sanctioned/excluded Providers in real-time.

- Deny any Drug Claims from Prescribers who are excluded or suspended from the Medicare, Medicaid, or CHIP programs for FWA or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employ someone on this list.
- Deny any Drug Claim from a Prescriber that is on payment suspension and/or withhold under the authority of LDH or its authorized agent(s).
- Edit Drug Claims based on specific characteristics of the Prescriber by specialty and/or therapeutic class of the prescribed drug(s), as directed by LDH.
- Limit Drug Claim approval for selected products, classes, or specific LDH programs to authorized Prescribers (e.g., use DEA Active Controlled Substance Registrant's File for controlled substance prescribing authorization, limit certain dosage forms of buprenorphine to Prescribers with an X-DEA number).

2.1.9.14.4 Pharmacy Enrollment

The Contractor shall:

- Validate that the Provider is currently enrolled with LDH to provide services under the Louisiana Medicaid Program.
- Validate that the Provider has a current Provider Agreement with the Contractor.
- Validate that the Provider is currently registered with the MCO.
- Validate that the Provider is in good standing with the Louisiana Board of Pharmacy and meets the requirements set forth the *Pharmacy and Prescriber Network* section of this RFP.
- Deny Drug Claims for controlled drugs from Providers whose license to practice has been restricted or revoked by the responsible licensing board or other regulatory agencies of authority (e.g., Drug Enforcement Agency).
- Update the list of sanctioned/excluded Providers in real-time.
- Deny any Drug Claims from Providers who are excluded or suspended from the Medicare, Medicaid, or CHIP programs for FWA or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employ someone on this list.
- Deny any Drug Claim from a Provider that is on payment suspension and/or withhold under the authority of LDH or its authorized agent(s).
- Determine if the Provider was eligible to perform the services requested and/or was eligible to receive reimbursement for the billed service on the DOS based on the Adjudication rules.
- Deny payment for services rendered by an ineligible Provider in accordance with State and Federal laws, rules, regulations, policies, procedures, manuals, and guidance.
- Edit Drug Claims based on specific characteristics of the Provider by specialty and/or therapeutic class of the prescribed drug(s), as directed by LDH.
- Limit Drug Claim approval for selected products, classes, or specific LDH programs to authorized Network Providers (e.g., use DEA Active Controlled Substance Registrant's File for controlled substance prescribing authorization, limit certain dosage forms of buprenorphine to Prescribers with an X-DEA number).

2.1.9.15 POS Drug Claims System Requirements

The Contractor shall:

- Conduct online POS operations twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year no less than ninety-nine and nine-tenths percent (99.9%) of the time, except for scheduled downtime pre-approved by LDH.
- Notify the MCOs and LDH in advance regarding scheduled downtime occurrences.
- Measure and report system up-time monthly.
- Notify LDH and the MCOs of performance issues impacting POS Adjudication within thirty (30) minutes of the Contractor's knowledge of system problems.
- Edit Drug Claims to ensure compliance with all Louisiana regulations, including but not limited to, quantity limits, age limits, day supply, without exception.
- Validate that the quantity of product is consistent with drug-specific therapeutic efficacy limitations, including any day supply limitations and frequency limitations.
- Include accumulation edits to prevent the continuously early filling of prescriptions.
- Automatically inform the Network Provider if the current Drug Claim is an exact or possible duplicate and deny that Drug Claim as appropriate (Duplicate Drug Claims).
- Edit Drug Claims to identify Dual Eligible Enrollees and deny Drug Claims covered by Medicare.
- Maintain indicators to identify Medicare Part B drugs and properly apply Medicare Part B payment before Medicaid payment for those dually enrolled.
- Deny payment for products covered by Medicare Part D when the enrolled individual has any Medicare coverage.
- Accommodate the processing of NDC-coded Drug Claims from Durable Medical Equipment (DME) Providers for State preferred diabetic supplies.
- Adhere to and enforce the LDH-preferred diabetic supplies list.
- Ensure the processing and Adjudication of Drug Claims for over-the-counter products and non-pharmaceuticals (e.g., DME, diabetic supplies, enteral products) as point-of-sale Drug Claims, as directed by LDH.
- Provide the ability to identify, at a Drug Claim level, the benefit plan under which the Drug Claim was processed (e.g., Medicaid, Dual Eligible, Hospice).
- Provide NCPDP standard messages in addition to customized response messaging as specified by LDH for its current or future programs including, but not limited to:
    - Bill [Primary Health Plan] and [phone number] and BIN/PCN, Enrollee ID number and group number for Primary, identifying each MCO separately.
    - Bill Medicare Part B.
    - Bill Medicare Part D [plan name] and [phone number] and BIN/PCN, Enrollee ID number and group number for Medicare D.
    - Program has no pharmacy benefit.
    - Bill as Medical Supply.
    - PA required or PA expired on [date].
    - Drug not covered – included in long-term care/hospice per diem rate.
    - Prescriber not authorized, pharmacy not authorized, Prescriber/NDC not authorized, or pharmacy/NDC not authorized.

- Provide functionality to apply different reimbursement logic or benefit coverage as specified by LDH including:
  - Ingredient Cost, Professional Dispensing Fee, and Provider Fee payments based on Provider for compounded drugs, 340B drugs, Specialty Drugs, Local or Non-Local Pharmacy, and other criteria as determined by LDH. Professional Dispensing Fees are applied to Drug Claims fully and solely in accordance with LDH rules and policies and are reimbursed only to Provider types entitled to receive Professional Dispensing Fees.
  - Based on program, category code or other program specifications, Enrollee age, drug or drug class, Medicare-Medicaid dual eligibility, Enrollees residing in a nursing facility, and other criteria as determined by LDH.

2.1.9.16 Drug Claim Edits

The Contractor shall:

- Support a hierarchy/priority when applying edits, based on LDH-defined business rules (e.g., Provider, business area, State, Federal policy).
- Maintain documentation for all edits that includes, but is not limited to, the history, origin, and modifications and provide at LDH's request.
- Develop and maintain a current list of all edits and identify those edits that require PA and provide to LDH quarterly.
- Establish the ability and supporting processes to override any edit that causes a Drug Claim to deny, when directed to do so by LDH.
- Provide testing (non-production environment where mass adjustment events can be modeled based upon actual Drug Claim experience) for any modifications to edits and review the results with LDH prior to implementation (e.g., affected Drug Claim count, net financial impact, supplemental encounter files generated).
- Conduct and complete testing to confirm accuracy of those changes and receive approval from each MCO prior to implementing any configuration change in the production environment.
- Maintain Drug Claim edits that enforce LDH-specified conditions to be met for Drug Claims payment.
- Maintain, on the Drug Claim record, the edits that were triggered by the Drug Claim and the disposition of each edit on the Drug Claim.
- Maintain edits, PA programs, override codes and business processes to support "emergency supply" provisions for covered outpatient drugs in compliance with Federal requirements and as directed and approved by LDH.
- Ensure that the prescription has not expired, and the number of valid refills has not been exceeded (Prescription Validity).
- Provide the ability to apply an Internal Control Number (ICN) to each Drug Claim and its supporting documentation, regardless of submission format, to track Drug Claims, conduct research, perform reconciliations, and for audit purposes.

- Ensure the system can add, change, or remove Adjudication processing rules to accommodate State and Federal required changes to the pharmacy program within thirty (30) Calendar Days, unless otherwise approved.
- Identify and deny Drug Claims that contain invalid prescribing Provider numbers including where the National Provider Identifier (NPI) or prescribing Provider number is missing or is invalid.
- Identify any TPL and ensure that the Louisiana Medicaid Program is the payer of last resort.
- Develop and maintain NCPDP-compliant cost avoidance and TPL edits that conform to applicable Federal and State laws, rules, regulations, policies, procedures, and manuals and the State Plan to ensure that the Louisiana Medicaid Program is the payer of last resort.
- Always follow NCPDP guidance to utilize the Other Payer Amount Paid (OPAP) methodology for Government Programs Coordination of Benefits (COB).
- Integrate the eligibility file containing other insurance indicator codes along with scope and term of coverage daily.
- Validate Drug Claims to determine whether there is a liable third party (or parties) that shall be billed prior to billing LDH including, but not limited to:
    - Utilizing LDH eligibility and supplemental TPL data, Contractor's TPL resources, and any other available sources of TPL data to ensure that all prior payment opportunities are utilized.
    - Correctly coordinating benefits and processing Drug Claims where multiple third parties are liable before and/or after the MCO.
    - Denying payment until the Drug Claim has been Adjudicated by the other potentially liable payer(s) or the Network Provider submits a valid override.
    - Obtaining maximum cost avoidance and reimbursement for Enrollees covered by third parties.
- Edit for quantity and Morphine Milligram Equivalent (MME) limits for a specified time across multiple Drug Claims.
- Allow a maximum amount of acetaminophen per day across multiple acetaminophen-containing drugs per day(s)/month/year and other accumulation edits as directed by LDH.
- Edit for products requiring submission of specific diagnosis codes at POS. Diagnosis codes may be pharmacy-submitted on the Drug Claim or derived historical Drug Claims (Diagnosis-Specific Requirements).
- Support NCPDP multi-ingredient compound functionality to process compounded Drug Claims and implement policy and procedures with LDH approval.
- Manually review and approve or deny within twenty-four (24) hours one hundred percent (100%) of multi-ingredient compounded Drug Claims that exceed the established dollar limit threshold to validate the medical necessity of the compound, commercial availability, and other clinical criteria approved by LDH.
- Adjudicate and reimburse Drug Claims for compounded drugs at ingredient level detail. A compound policy shall be developed in accordance with LDH guidance.

- Calculate and notify LDH of any retroactive rate, program changes, or retroactive changes in Enrollee eligibility that requires Drug Claim adjustments.
- Apply a predetermined set, or sets, of parameters that may reverse or amend incorrect transactions which paid incorrectly, or denied incorrectly, and repay them correctly.
- Adjust or void incorrect Drug Claims payments in accordance with the MCO Manual.
- Notify LDH and the MCO(s) of all Drug Claims that have been erroneously processed within one (1) Business Day of discovery and immediately initiate appropriate action to correct the errors (e.g., adjustments, recoveries).
- Reprocess Drug Claims when the Contractor, a Subcontractor, a Network Provider, an MCO, LDH or its designee discovers errors that occurred when a Drug Claim was Adjudicated. The Contractor shall make corrections and reprocess the Drug Claim within five (5) Business 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 Network Providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable Drug Claim remains unpaid beyond either the five (5) Business Day Drug Claims reprocessing deadline or the specified deadline approved by LDH in writing, whichever is later. The Contractor shall automatically recycle all impacted Drug Claims for all Network Providers and shall not require the Network Provider to resubmit the impacted Drug Claims.

2.1.9.17 Third Party Liability

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 Drug Claims before the Contractor pays for the care of an Enrollee.

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.
- Receive, process, and update all records included in TPL Master Resource File sent daily by LDH or its designee within one (1) Business Day of receipt.
- Reconcile its system with TPL reconciliation file sent weekly by LDH or its designee within one (1) Business Day of receipt.
- Verify and update its system within four (4) Business Hours of receipt of an update request, if an Enrollee is unable to access PBM Covered Services until the update is made. This includes updates on coverage, including removal of coverage that existed prior to the Enrollee's linkage to the MCO that impacts Adjudication or Enrollee access to PBM Covered Services.
- If there is no record of TPL, the Contractor shall Adjudicate the Drug Claim.

2.1.9.17.1 Cost Avoidance and Pay and Chase

The Contractor shall:

- Cost-avoid a Drug Claim if it establishes the probable existence of TPL at the time the Drug Claim is filed, except for "pay and chase" Drug Claims identified in the MCO Manual.
- "Pay and chase" the full amount allowed under its payment schedule for the Drug Claim and then seek reimbursement from the liable third party. 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 TPL), pursue recovery from the liable third party to the extent of any legal liability.
- "Wait and see" on Drug 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 Drug Claim only after documentation is submitted to the Contractor demonstrating that one hundred (100) Calendar Days have elapsed since the Network Provider billed the responsible third party and the Network Provider has not received payment for such services.

2.1.9.17.2 Post-Payment Recoveries

If TPL is identified after a Drug Claim has been Adjudicated, the Contractor shall:

- Initiate recovery of reimbursement within sixty (60) Calendar Days after the end of the calendar month in which the TPL is identified.
- Not perform post-payment recovery for TPL from Providers for Drug Claims with dates of service (DOS) older than ten (10) months, except when the liable third party is traditional Medicare, Tricare, or CHAMPUS.
- Recover from the Provider if the liable third party is traditional Medicare, Tricare or CHAMPUS, and more than ten (10) months have passed since the DOS.
- 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.
- Refer pay and chase Drug Claims directly to the liable third parties.
- Refer Point of Sale (POS) Drug Claims directly to the carrier.
- Initiate an automatic recoupment at the expiration of the sixty (60) Calendar Day time period if an extension request is not received from the Network Provider and at the expiration of the ninety (90) Calendar Day time period if an extension is requested by the Network Provider if the Network Provider has not remitted the payment to the Contractor.
- 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.
- Identify the existence of potential TPL to pay for PBM Covered Services through the use of trauma code edits in accordance with 42 CFR §433.138(e).
- Seek reimbursement in accident/trauma related cases when Drug 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 Drug 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.

- Notify LDH when subpoenas duces tecum are received and report the resulting recoveries to LDH.
- The amount of any recoveries collected by the Contractor outside of the Drug Claims processing system shall be treated by the Contractor as offsets to medical expenses for the purposes of reporting.
- Obtain written approval from LDH prior to accepting a TPL settlement on accident/trauma-related Drug Claims equal to or greater than twenty-five thousand dollars ($25,000.00).
- 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.
- 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.
- When the Contractor has actual knowledge that an insurer or other risk bearing entity of an Enrollee has filed for bankruptcy and the Network Provider files a Drug 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 Network 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 Network 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 Network Provider files a Drug 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 Network Provider files a Drug 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.
- Transfer one hundred percent (100%) of its TPL recoveries to the appropriate MCO.

- Void encounters for Drug 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 Drug Claims.
- Provide TPL information to the MCO in a format and medium described in the MCO Manual and shall cooperate in any manner necessary, as requested by the MCO, with the MCO and/or its designee.

2.1.9.17.3 LDH Right to Conduct Identification and Pursuit of TPL

LDH may invoke the Contractor's 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 Drug Claim(s).

If the MCO 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 V, *Table of Monetary Penalties*.

2.1.9.17.4 Coordination of Benefits

The Contractor shall:

- Report all available TPL information to billing Network Providers when another payer is primary including, but not limited to:
  - The payer's Bank Identification Number (BIN), Processor Control Number (PCN), and Group Number, as available.
  - The Cardholder Identification number assigned by the payer.
  - Other available payer names, identifiers, and phone numbers, as message space allows.
- Provide the ability for single and repeating overrides of TPL data, regardless of source, if the Network Provider has acted in good faith and the primary payer does not exist or has expired.
- Conduct post-payment review of the utilization of any TPL overrides to ensure appropriate use and identify potential overuse of overrides.
- If TPL is involved, the Contractor, as the secondary payer, may not deny the Drug Claim for a high dollar amount billed for Drug Claims less than one thousand five hundred dollars ($1,500).
  - If the primary payer pays $0.00 or denies the Drug Claim, then the Drug Claims shall be treated as a straight Louisiana Medicaid Program Drug Claim, with all applicable edits applied.
    - Taxes on the primary Drug Claim shall be subtracted before calculating the MAC.
    - The pricing calculation is ingredient cost (quantity * price per unit) + Professional Dispensing Fee – TPL amount paid – copayment = payment.
    - If the U&C Charge is less than the MAC, then the calculation is U&C Charge – TPL amount paid – copayment = payment.

- If the primary payer pays more than $0.00, the Contractor shall:
  - Electronically bypass PA requirements and Point of Sale edits that would not be necessary as the secondary payer. Safety edits shall still apply.
  - Not reimburse the Provider Fee.
  - Process TPL Drug Claims with the same PCN and BIN number as primary Drug Claims.
  - Adjudicate primary and coordinated benefit Drug Claims for LDH's current programs and any future programs consistent with LDH's coverage and reimbursement policies and procedures.

Table 1: Scenario: Outpatient Drug Claim

Amount Billed	TPL Paid Amount	MAC	Patient Responsibility Amount from Primary	Medicaid Pharmacy Co-Pay	Medicaid Payment
38.55	28.55	31.36	10.00 (Copay)	0.50	2.31
613.00	60.00	40.73	553.00 (Ded)	0.00	0.00
177.97	5.22	14.39	172.75 (Ded)	0.50	8.67

2.1.9.18 Paper Drug Claims

The Contractor shall provide the ability to process Drug Claims electronically as well as by batch electronic media and paper Drug Claims submitted directly for processing. Paper Drug Claims include, but are not limited to, those submitted for retroactively eligible Enrollees. Paper Drug Claims shall be HIPAA compliant and submitted on the NCPDP Universal Claim Form Version D.0, or most current version.

The Contractor shall:

- Utilize NCPDP Telecommunication and Batch Standards, including, but not limited to, the B1, B2, and B3 transactions.
- Adjudicate one hundred percent (100%) of Network Provider-initiated paper Drug Claim adjustment requests within fourteen (14) Calendar Days of receipt.
- Process paper Drug Claims for the term of the contract and for a period of twelve (12) months after the contract term date, if requested by LDH.
- Create electronic imaged copies of all paper Drug Claims and attachments within one (1) Business Day of receipt.
- Make imaged copies of paper Drug Claims available for LDH review through access to the Drug Claims processing system or other online portal supplied by the Contractor.
- Utilize quality and validation procedures to ensure accuracy of the information obtained from paper Drug Claims submitted and validate data entry before it is Adjudicated.
- Return Drug Claims with invalid or incomplete information to the submitting Provider along with a cover letter template approved by LDH explaining the reason why the Drug Claim(s) is being returned within one (1) Business Day of receipt of the Drug Claim(s) that cannot be processed.

- Provide efficient handling of paper records when electronic processes are not able to accommodate unique Drug Claims.
- Process an adjusted Drug Claim accurately through all edits, audits and pricing logic applied to an initial Drug Claim.
- Validate each required data element of the Drug Claim record for valid values, correct format, and completeness.
- Provide the capability of identifying unique Drug Claims and tracking them throughout their lifecycle and through any number of reversals and resubmissions.

2.1.9.19 Drug Claim Audit Logs

The Contractor shall:

- Provide automated system audit trails to document, identify, and track chronological records and transactions throughout its system(s), including all actions (e.g. additions, deletions, and changes to drug data maintenance, business rules, system configuration, user access, etc.).
- Capture data to include user information, date, time, and other audit log data as appropriate.
- Produce robust audit trails and audit logs of all applications and engineering activities (including inquiry transactions) on the production systems.
- Retain audit logs and make them available to LDH in accordance with the LDH Records Management policy.
- Establish policies, procedures, and practices to ensure there is appropriate internal monitoring of the audit logs and the established process produces documentation to evidence the monitoring effort.
- Capture and maintain audit logs containing message types (e.g., security messages, incoming and outgoing requests and responses, internal processing messages, error messages).
- Archive log messages per State records retention policies.

2.1.9.20 Systems Documentation

The Contractor shall:

- Develop and maintain written systems process and procedure manuals and other documentation that document and describe all manual and automated system procedures for its information management processes and information systems, in accordance with State standards.
- Develop, prepare, print, maintain, produce, and distribute to LDH, or its designee(s), and the MCOs distinct systems design and management manuals, user manuals, and quick reference guides, and any updates.
- Ensure that abbreviations and acronyms are defined and consistent throughout the manuals and quick reference guides.
- Ensure the systems user manuals contain information about, and instruction for, using applicable systems functions and accessing applicable system data.

- Provide descriptions of error messages for all field edits, including the necessary steps to correct such errors.
- 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.
- Ensure all manuals and quick reference guides are available in printed form and online.
- Update the electronic version of the manuals and quick reference guides immediately, and update printed versions within ten (10) Business Days of the update taking effect.
- Provide authorized users access to current and historical manuals and quick reference guides.
- Identify all revisions and maintain history with change date of all revisions to manuals and quick reference guides. Make such revision history available to LDH, or its designee, and the MCOs upon request.
- Provide and maintain electronic documentation that details the pricing structure and associated functionality provided by the system.

All required documentation must be submitted to LDH or its designee for review and approval as part of Readiness Review.

The Contractor shall provide a Systems Refresh Plan to LDH or its designee for review and approval as part of Readiness Review and sixty (60) Calendar Days prior to implementation of revisions. The Systems Refresh 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. The systems refresh plan shall also indicate how the Contractor shall ensure that the version and/or release level of all of its systems components (application software, operating hardware, and operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the systems component.

2.1.9.21 Defect Management

The Contractor is responsible for resolving Defects and related issues according to the severity, impact, and priority classification specified herein. LDH and the MCOs shall not be liable for the cost of any change order related to resolving Defects and related issues.

2.1.9.21.1 Severity

The following are severity classifications:

- Critical: A failure or significant degradation of service affects all users where there is no alternative or workaround, and it causes significant negative impact to security, business operations and/or financial implications.

- High: A failure or degradation of service causing moderate disruption to business with negative security or financial implications where there is no alternative or workaround.
- Medium: A degradation of service causing partial or limited functionality, without a failure. Issue has a possible workaround.
- Low: A non-substantial defect, incident, or issue that does not present an interruption in service and has limited to no business impact.

2.1.9.21.2 Impact

The following are impact classifications:

- Complete: Affects all users.
- Widespread: Affects a majority of all users.
- Localized: Affects less than half of all users.
- Isolated: Affects a small number of users.

2.1.9.21.3 Priority

An initial Priority should be assigned for user-reported problems to ensure that the most serious problems are addressed first. The following are priority classifications:

- Critical Priority: Multi-component or critical functionality outages. Serious disruption to State business where there is no alternative or workaround. Severe security impact, significant impact to business operations, and/or negative financial implications to the State.
- High Priority: Single component or single critical functionality outage. Moderate disruption to State business where there is no alternative or workaround. Negative security and/or financial implications to the State.
- Medium Priority: Partial or limited functionality of the system or a component causing a negative operational impact for the State or delay to daily State business processes. Issue has a possible workaround.
- Low Priority: Affects a small number of users with limited to no business implications to the State. Problem concerning minor items with no negative Impact to system functionality or State business processes.

Priority	Performance Expectation	Response	Updates to State
Critical Priority	**Resolution or plan for resolution**: Within one (1) hour of a critical priority production issue being reported, Contractor initiates a conference call/meeting to determine a Rapid Action Plan (RAP).	24x7 Response until incident is downgraded or resolved.	Every 1 hour or as requested by State.

Priority	Performance Expectation	Response	Updates to State
High Priority	**Resolution or plan for resolution:** Within four (4) hours of a high priority production issue being reported, Contractor initiates a conference call/meeting to determine a Rapid Action Plan (RAP).	Hourly monitoring until incident is downgraded or resolved.	Every 4 hours or as requested by State.
Medium Priority	**Resolution or plan for resolution**: Plan for resolution will be defined between the Contractor and State.	As requested by State, with a minimum of daily monitoring.	As requested by State.
Low Priority	**Resolution or plan for resolution**: Plan for resolution will be defined between the Contractor and LDH.	As requested by State.	As requested by State.

2.1.10 Covered Drug List (CDL) / Preferred Drug List (Single PDL)

In accordance with 42 CFR §438.3, the Contractor shall maintain a Covered Drug List (CDL) which includes all outpatient drugs for which the manufacturer has entered into a Federal rebate agreement and meet the standards in Section 1927 of the Social Security Act.

The Contractor shall:

- Include all drugs deemed medically necessary for Enrollees under the age of twenty-one (21).
- Exclude only those drugs or drug categories permitted for exclusion under 42 USC §1396r-8(d), with exceptions listed in the State Plan.
- Cover, at a minimum, all vaccines and administration covered by FFS.
- Be updated at least weekly using a national drug database Medicaid rebate module.

The Contractor may apply Point of Sale safety and utilization edits that align with FDA indications for any covered drug when approved by LDH.

The Contractor shall:

- Deny payment for any drug that CMS identifies as restricted/non-covered.
- Deny payment for drugs that the Federal government has identified as less-than-effective under the Drug Efficacy Study Implementation (DESI) program.
- Deny payment for non-preferred products (without an approved PA) and products or product classes not covered by an Enrollee's pharmacy program with specific Provider messaging in the Drug Claim response.
- Allow exceptions as they are approved by LDH or based on LDH-approved criteria.

- Provide the ability to look up the PDL status of a drug at a Drug Claim and NDC level in the Drug Claims processing system.
- Edit for required PAs and support bypass/override when allowed by policy, date of dispensing or automated authorization based on pharmacy or medical claims history (e.g., step therapy, grandfathered coverage).
- Provide a system capable of supplying PA expiration dates in pharmacy messaging.
- Have the capability to process Drug Claims for the MCOs when they have designated value-added pharmacy products. When drugs (OTC or legend) are being covered as a pharmacy benefit and offered as a value-added benefit, pharmacy encounters shall indicate such in the Character 1: Submission type (Q, F, or V) of the 4-character prefix on the ICN of the Rx encounter.
- Cover self-administered drugs dispensed by a pharmacy, including Specialty Pharmacies, as a pharmacy benefit exclusively unless otherwise approved by LDH.
- Cover physician-administered drugs that are not listed on the FFS fee schedule, but for which the manufacturer has signed a Federal rebate agreement, as either a pharmacy benefit or a medical benefit that ensures appropriate access. If the physician administered drug is not on the FFS fee schedule, the Contractor shall make the rebate eligible drugs payable as a pharmacy benefit, and reimbursement shall be set as directed by LDH.

The medications listed in the U.S. Preventive Services Task Force (USPSTF) A and B Recommendations shall be payable as a pharmacy benefit and exempt from copay; corresponding age limits may be applied.

2.1.10.1 Preferred Drug List

A subset of the Covered Drug List (CDL) shall be the PDL. The PDL is established by LDH and indicates the preferred and non-preferred status of covered drugs. The PDL is available on the LDH website: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf.

The FFS PBM shall provide the Contractor with a weekly file at the National Drug Code (NDC) level reflecting the PDL and any restrictions, as well as any utilization management updates to drugs subject to the PDL. The Contractor shall implement changes within three (3) Business Days of the receipt of the changes, or the effective date of the change, whichever is later unless otherwise approved by LDH.

To ensure compliance with PDL General Requirements, the Contractor shall:

- Implement the PDL into the POS Adjudication as specified by LDH, without exception, uniformly across all MCOs.
- Make the PDL available to Providers and Enrollees through electronic prescribing tools and a static link on the Contractor's website to the PDL maintained on the LDH website.
- Provide Enrollees with a printed version of the PDL upon request at no charge.

2.1.10.1.1 PDL Changes

LDH shall provide the Contractor with:

- A list of drugs included on the PDL by NDC number after each P&T Committee meeting and upon the Secretary's approval of the P&T Committee recommendations.
- At least thirty (30) Calendar Days written notice prior to the implementation date of any scheduled changes to the PDL.

To ensure compliance with PDL changes, the Contractor shall:

- Implement changes by January 1 and July 1 after the P&T Committee meeting, unless otherwise directed by LDH.
- Designate a representative to attend every P&T Committee meeting.
- Identify Enrollees impacted by a PDL status change. Brand/generic preference changes of the same drug entity do not constitute a negative PDL change.
- Meet with LDH and other LDH-specified contractors, at a minimum quarterly, to review new drugs to market and support LDH and its designee(s) to implement PA criteria when needed.
- Add new drugs entering the marketplace in PDL therapeutic classes as non-preferred until the P&T Committee reviews the drug, unless otherwise directed by LDH.
- As needed, add new therapeutic classes and associated edits (i.e., preferred/non-preferred, clinical criteria, etc.) based upon the activity of the P&T Committee or the introduction of new therapies to the market.
- Ensure that, if a branded product is preferred on the PDL, the Prescriber does not need to specifically indicate in writing that the branded product is medically necessary.
- Reimburse for a brand name drug at a brand reimbursement when the brand drug is preferred.
- Provide POS denial messaging for the generic entity that indicates the brand name is preferred.
- Allow grandfathering for at least sixty (60) Calendar Days after a negative PDL status change as directed by LDH.

2.1.10.1.2 PDL Compliance

Compliance rate shall be defined as the number of preferred prescriptions paid divided by total prescriptions paid for drugs in therapeutic classes listed on the PDL. The PDL compliance rate shall be calculated at the sole determination of LDH or its designee.

To ensure conformity with PDL compliance, the Contractor shall:

- Achieve at least a ninety-two percent (92%) overall compliance rate and at least a ninety-two percent (92%) compliance rate for each medication on the brand-over-generic list provided by LDH (calculated as brand/ (brand + generic)). Failure to meet both standards may result in monetary penalties.
- Measure the accuracy of its implementation and maintenance of the PDL and report findings to LDH monthly. Monthly reports shall include an attestation from the Contractor's Executive Director as to the accuracy of the measurement.

- Ensure Enrollee continuity of care for pharmacy services. An Enrollee that is, at the time of enrollment into the MCO, receiving a prescription drug that is not on the PDL shall be permitted to continue to receive that prescription drug if medically necessary for at least sixty (60) Calendar Days. The Contractor shall not require PA for the continuation of medically necessary PBM Covered Services of an Enrollee transitioning into a new MCO for the duration of a currently approved PA.
- 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.

2.1.10.2 Prior Authorization (PA)

The Contractor shall:

- Utilize PA criteria as directed by LDH and align with drugs on the PDL.
- Comply with the MCO Manual.
- Solicit input from the MCOs on PA criteria development and representation on the DUR Board.
- Have a PA process that complies with 42 CFR §438.3(s)(6) and the following requirements:
  - Process the entire PA transaction in accordance with applicable laws, regulations, and LDH-approved requirements. The PA transaction for which the Contractor is responsible includes rendering PA determinations; resolving Enrollee and Provider Grievances and Appeals; resolving Provider requests for reconsideration of adverse PA decisions; and issuing PA decision notices, whether the PA is approved, partially approved, or denied, both to the requesting Provider and to the Enrollee on whose behalf the PA was sought.
- Submit the PA process flow and notification format for approval by the LDH prior to implementation and before any changes are made.
- Disclose operational criteria and updates to LDH on a frequency determined by LDH for review and approval.
- Ensure there is no undue disruption of an Enrollee's access to care.
- Prevent penalization of a Network Provider or Enrollee, financially or otherwise, for such PA requests or approvals.
- Incorporate the following minimum requirements:
  - Maintain a single PA program that serves all MCOs and prevents administrative duplication.
  - Use a uniform PA process for all MCOs.
  - Not maintain separate PA programs for each MCO, nor alter or customize PA processes for each MCO, except when necessary for a MCO specific value-add benefit.
  - Adhere to the provisions of La. R.S. 46:153.3(C)(1), which exempt HIV/AIDS drugs from PA.
  - Correctly determine which drugs require PA.

        - Prior authorize drugs with a non-preferred status on the PDL or with clinical authorization requirements.
        - Not prior authorize drugs with a preferred status on the PDL, except to align with clinical edits.
        - Not prior authorize drugs not on the PDL/PA list for self-administered drugs, except to align with clinical edits or as otherwise directed by LDH.
        - Prior authorize drugs when safety and utilization edits are exceeded when approved by LDH, except for drugs used for the treatment and prevention of HIV/AIDS.
    - Align PA criteria and/or step therapy related to the preference of one agent over another agent within a therapeutic class listed on the PDL. Application of PA and/or step therapy criteria more restrictive than FFS may result in daily monetary penalties.
    - Not apply PA and/or step therapy to preferred agents listed on the PDL in a manner that would disadvantage the selection of the preferred agents over other agents within the therapeutic class.
- Utilize the Louisiana Uniform Prescription Drug PA Form provided for in La. R.S. 46:460.33.
- Utilize the LDH form and criteria for specialty drug therapeutic classes filled in an outpatient pharmacy setting. The following therapeutic drug classes are currently considered specialty for PA purposes only: Hepatitis C Direct Acting Antiviral Agents (as directed by LDH), Spinraza and Synagis.
- Ensure only LDH-approved PA criteria are used in conducting PA reviews and making PA determinations based on medical necessity and in accordance with all applicable State and Federal laws and regulations.
- Comply with all LDH PA rules, regulations, criteria and policies.
- Have the capability to implement a PA program for physician-administered drugs as a Drug Claim, upon implementation by LDH. The Contractor may be asked to implement PA program for physician-administered drugs as a medical claim.
- Maintain a PA process for which scripted protocols may be used to approve PA service requests. The Contractor may use pharmacy technicians in this capacity.
- Not require a Prescriber to complete the FDA Medwatch form when requesting a brand name medication that has a generic equivalent.
- Not require or consider a Medwatch form in the PA approval/denial determination of a brand drug.
- Not utilize PA to prefer a FDA interchangeable B-rated generic drug over an A-rated generic.
- Not require PA for a dosage change for any medications (including long-acting injectable antipsychotics) and other medication assisted treatment (including dosages of buprenorphine or buprenorphine/naloxone) that have been previously authorized and/or approved by the Contractor, as long as the newly prescribed dose is within established FDA guidelines for that medication.

- Approve a PA for the requested product for a narrow therapeutic index (NTI) drug (brand or generic) with current utilization. Current NTI drugs designated by LDH include: Aminophylline, Carbamazepine, Cyclosporine, Digoxin, Disopyramide, Ethosuximide, Flecainide, L-Thyroxine, Lithium, Phenytoin, Theophylline, Thyroid, Valproic Acid, and Warfarin.
- Supply detailed reporting and analysis on all aspects of the PA program.
- Provide a PA system, accessible to designated LDH staff and Providers, which maintains and allows the query of all pertinent information about PA requests and determinations including, but not limited to, the following:
    - Requesting Provider name
    - Date and time of request
    - Enrollee identifiers
    - Requested drug name, strength, form, and quantity
    - Program eligibility of the Enrollee at the time of the determination
    - Request status (i.e., approved, pended, denied)
    - Apply specific reasons for denial or exception
    - Ability to track and report specific reason for denials
    - Authorized begin and end dates
    - Date and time of action on the request
    - Comprehensive and flexible “free-text” notation functionality
- Have flexible administrative reporting and include functionality to retrieve and track PA determinations using multiple search fields including, but not limited to:
    - Assigned PA number
    - Pharmacy program
    - Enrollee name
    - Enrollee identification number
    - Provider name or ID
    - Drug
    - Date of authorization
    - Denial reason(s)
    - Authorization status or any combination thereof
- Provide detailed monthly operational, clinical, and financial reporting on all PA activities. Reports shall be available by drug, drug class, Provider, and other defined parameters. PA reports shall include, but not be limited to:
    - Number of PAs
    - Denial/approval rates
    - Number of automated vs. manual PAs
    - Drug
    - Overall health care savings
    - Return on investment
- Provide all PA activities and decisions in detail and written in layman’s language and which shall be available for immediate and unredacted review by the MCOs or LDH.
- Migrate all existing automated PAs into its automated PA application.

- Import and honor for use in real-time Drug Claims processing all unexpired existing PAs, regardless of whether they were manually or electronically approved.
- Allow an Enrollee, or a Provider on Enrollee's behalf, to Appeal PA denials.
- Allow and participate in State Fair Hearings in accordance with 42 CFR Part 438, Subpart F, when no resolution is reached through the Appeal process.
- Provide the MCO and LDH pharmacy staff real-time, unredacted, read access to view prior authorization records, at no cost to the MCO or LDH.
- Provide a toll-free twenty-four (24) hours per day, seven (7) days per week PA call center, staffed with appropriate clinical personnel accessible 7:00 am to 7:00 pm Central Time. Monday through Friday excluding agreed-upon holidays– except for downtime approved in advance by LDH.
- Staff the call center with appropriate technical and clinical staff sufficient to handle call volume.
- Locate the call center in Louisiana, for Prescribers to call to request PA for non-preferred drugs or drugs that are subject to clinical edits.

2.1.10.2.1 Prior Authorization Submission

To ensure compliance with the submission of PAs, the Contractor shall:

- Allow Prescribers to submit PA requests by phone, fax, mail or automated process.
- Include a review of the Enrollee's eligibility record as part of PA processing to retrieve the information needed for PA determinations including, but not limited to:
    - Program eligibility.
    - Authorized Prescribers.
    - Program coverage restrictions.
    - Alternative insurance (e.g., Medicare Part B, commercial coverage).
    - Other elements specified and approved by LDH.
- Allow determinations based on various data elements identifying drug products including, but not limited to, the following:
    - NDC 9 or 11.
    - Therapeutic class.
    - Other drug grouping categories as approved or directed by LDH.
- Pursue additional information from the requestor sufficient to render a final decision and, after an LDH-specified period has lapsed with no response, deny the request.
- Not penalize the Prescriber or Enrollee, financially or otherwise, for PA requests or other inquiries regarding prescribed medications.

2.1.10.2.2 Timelines and Adjudication of PAs

The Contractor shall:

- Approve or deny PA requests within twenty-four (24) hours of receipt, seven (7) days a week.
- The twenty-four (24) hour response for requests received via mail shall begin on the date and time the mail is received by the review department.

- Utilize a date and time stamp assignment system for all PA requests to allow for monitoring of the timeliness notification requirement.
- Provide denials of PA requests or offering of an alternative medication to the Prescriber and Enrollee in writing, including all the reasons the PA was denied.
- Notify the Enrollee, in writing using language that is easily understood by the Enrollee, of determinations to deny a PA 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.
- The Contractor shall notify the requesting Prescriber 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.
- Comply with the requirements of Section 1927 of the Social Security Act.
    - The MCOs shall hold the Contractor to a ninety-nine and one-half percent (99.5%) compliance rate with the twenty-four (24) hour PA resolution requirement.
    - If the Contractor is reporting less than ninety-nine and one-half percent (99.5%) compliance on the RX055 report, an explanation shall be included with the report in the notes section.
- Have an automated process that allows the Network Provider to dispense, without PA, a seventy-two (72) hour emergency supply of a product or full unbreakable package.
- Allow up to two (2) consecutive emergency supply fills per prescription, if needed.
- Reimburse the pharmacy for both the ingredient and the Professional Dispensing Fee for both emergency supply fills. Emergency fills may be included in a post payment review and shall be reported monthly to LDH to identify misuse.
- Have an automated PA functionality to automatically override PA requirements during Drug Claim processing based on data available from Drug Claims paid by the Contractor.
- Accept and integrate clinical data from other systems necessary for PAs and Adjudication, including diagnosis codes and lab values. The Contractor may be required to use those values in the PA and Adjudication processes, as required by LDH.
- Override PA for selected drug products or devices at LDH's discretion, including, but not limited to, certain DUR initiatives.

2.1.10.2.3 PA Denials, Appeals, and Escalations

The Contractor shall:

- Provide pharmacist review of all PAs that are deemed to be deniable and, if necessary or requested, forward to MCO medical director for review prior to the denial notification to the Prescriber/Network Provider. LDH and the Contractor shall jointly determine the types of reviews that shall be appropriately escalated to clinical staff.

- Provide a Louisiana Registered Pharmacist for call escalation regarding PA criteria and PA denial determinations.
- Provide a peer-to-peer reconsideration process within one (1) Business Day, administered by a board-certified physician, available to Prescribers who wish to challenge any adverse PA decisions, both before and after any Appeal.
- Notify the Enrollee when PA is denied.
- Comply with LDH and Federal policies and procedures for Enrollee Appeals including, but not limited to, the following:
  - Notify Prescribers and Enrollees of their Appeal rights.
  - Prepare the appropriate reports and documents to support its actions resulting in the request for an Appeal.
  - Appear at State Fair Hearings to defend a PA denial decision.
  - Provide the services of a clinical pharmacist to engage in peer discussions with LDH's Medical Director and other LDH clinical personnel to address an Appeal related to pharmacy benefit services.
  - Comply with the mandates and timelines stipulated by LDH and Federal policies for response/resolution of any Appeal.
- Provide informal reconsideration
  - As part of the MCO or 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.
  - 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 Benefit Determination by the physician or clinical peer making the Adverse Benefit Determination [42 CFR §438.402(c)(1)(ii)].
  - The informal reconsideration shall occur within one (1) Business Day of the receipt of the request and shall be conducted between the Prescriber rendering the service and the Contractor's physician authorized to make Adverse Benefit Determinations or a clinical peer.
  - The Informal Reconsideration does not extend the thirty (30) Calendar Day required timeframe for a Notice of Appeal Resolution.

2.1.11 Behavioral Health Policies and Procedures

The MCOs are responsible for contracting with psychiatric facilities and residential substance use facilities so that the MCOs are notified upon patient admission and upon patient planned discharge from the psychiatric facility or residential substance use facilities (including, but not limited to, inpatient psychiatric facilities, psychiatric residential treatment facilities (PRTFs), and residential substance use disorder settings).

Prior to discharge, the MCO shall be informed of the patient's discharge medications. The MCO shall then be responsible for notifying the Contractor to override or allow all behavioral health

discharge medications to be dispensed by overriding PA restrictions for a ninety (90) Calendar Day period. This includes, but is not limited to, naloxone, buprenorphine containing products, and long-acting injectable anti-psychotics. Also, if the Prescriber indicates on the universal PA form that the Enrollee is being discharged from a psychiatric facility or a residential substance use facility and the prescription is for a behavioral health medication (includes, but is not limited to, naloxone, buprenorphine containing products, and long-acting injectable anti-psychotics), the PA shall be immediately approved for at least ninety (90) Calendar Days.

However, these requirements are exempted if the MCO's psychiatrist, in consultation and agreement with the facility's prescribing physician, determines that the medications are:

- Not medically necessary; or
- Potentially harmful to the Enrollee.

PA shall be automatically approved upon notification to the Contractor by the Prescriber's office for a dosage change for any medications in behavioral health therapeutic classes (including long-acting injectable antipsychotics) and other medication assisted treatment (including buprenorphine containing products and naloxone), that have been previously authorized or approved, if the newly prescribed dose is within established FDA guidelines for that medication.

The Contractor shall continue any treatment of antidepressants and antipsychotics for at least ninety (90) Calendar Days after enrollment with the MCO.

2.1.12 Specialty Drugs and Pharmacies

The Contractor shall manage Drug Claims for Specialty Drugs, excluding establishment of a Specialty Pharmacy Network. LDH recognizes the importance of providing adequate access to Specialty Drugs to Enrollees while ensuring proper management of handling and utilization.

The Contractor shall not limit distribution of Specialty Drugs or self-refer to a MCO or Contractor-owned Specialty Pharmacy. Any pharmacy that is able to procure Specialty Drugs from distributors, has any one of the nationally recognized accreditations and is willing to accept the terms of the MCO's contract shall be allowed to participate in the Contractor's Network (any willing Provider).

All Specialty Pharmacy contracts between the Contractor and Specialty Pharmacy shall be sent to LDH for approval thirty (30) Calendar Days prior to processing any Drug Claim for Specialty Drugs. LDH reserves the right to deny Specialty Pharmacy contracts that include what LDH deems to be overly burdensome terms or requirements, including but not limited to requirements for excessive insurance coverage, unreasonable stocking requirements, or restrictive or duplicative accreditation requirements. The Contractor shall accept any one of the nationally recognized accreditation programs to meet its Specialty Pharmacy requirement. All pharmacy contract cancellations shall be approved by LDH at least sixty (60) Calendar Days prior to cancellation.

To ensure compliance with the access to Specialty Drugs, the Contractor shall:

- Not establish definitions, or require accreditation or licensure, effectively limiting access to prescription drugs, including Specialty Drugs.

- Not consider the following categories of drugs as Specialty Drugs:
  - Any oral medications utilized to treat HIV, Hepatitis B or Hepatitis C.
  - Any oral medications utilized to treat rheumatoid arthritis, multiple sclerosis or psoriasis (e.g., Aubagio, Gilenya, Otezla, Xeljanz/Xeljanz XR, etc.).
  - Any oral medications utilized to treat epilepsy or an immunosuppressant (e.g., Mycophenolate, Sirolimus, Tacrolimus, etc.).
  - Self-administered injectable anticoagulants (e.g., Enoxaparin, Fondaparinux, Dalteparin, Unfractionated heparin, etc.).
  - Self-administered injectable human growth hormone (excluding drop-ship items) or self-administered medications for migraine prophylaxis (e.g., Aimovig, Ajovy, Emgality).
  - Self-administered TNF-alpha blockers (e.g., Enbrel, Humira, Simponi, Cimzia), multiple sclerosis agents (e.g., Copaxone, Interferons, etc.) or psoriatic conditions (e.g., Cosentyx).
- Provide a quarterly list of identified Specialty Drugs to LDH and the MCOs and post on the Provider website after LDH approval.

2.1.13 Drug Utilization Review

The Contractor shall participate in the LDH DUR program to assure that outpatient drugs are appropriate, medically necessary, and are not likely to result in adverse medical results in accordance with 42 USC §1396r-8(g).

DUR standards shall encourage proper drug utilization by ensuring maximum compliance, minimizing potential Fraud and Abuse, and take into consideration both the quality and cost of the pharmacy benefit.

The Contractor shall:

- Participate and implement edits accordingly.
- Attend every LDH DUR board meeting.
- Follow the safety edits and Drug Claims review requirements as specified by the State to comply with the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act.

2.1.13.1 Prospective DUR Review

The Contractor shall:

- Provide for a Prospective Drug Utilization Review (ProDUR) program as specified under State and Federal laws, rules, regulations, policies, procedures, and manuals.
- Provide a system with a ProDUR function that meets minimum Federal Drug Utilization Review (DUR) regulations as well as any additional specifications defined by LDH and be flexible enough to accommodate all future edit changes identified by LDH or the DUR board. The Contractor may use an existing ProDUR package but shall make any modifications required by LDH at no cost to LDH or the MCO.
- Provide a dedicated programmer to implement POS utilization review edits as requested by LDH, including, but not limited to configuring existing benefit design, eligibility, DUR,

Drug Claim edits, and drug pricing functionality as well as developing enhancements to the POS system as directed by LDH staff.

- Participate in the Retrospective Drug Utilization Review (RetroDUR) program and a DUR Educational program with LDH or a LDH contractor and provide reports as requested to LDH and the MCOs.
- Produce Enrollee profiles for RetroDUR initiatives in an LDH approved format. MCOs are allowed to implement Retrospective DUR initiatives that do not duplicate LDH RetroDUR upon LDH approval.
- Implement Prospective DUR initiatives as directed or with written LDH approval of alternative programming reaching the same outcomes. DUR initiatives not or incorrectly implemented may result in monetary penalties.

2.1.13.2 Prospective DUR System

The Contractor's system shall:

- Provide ProDUR services that apply edits to all Drug Claims.
- Work with LDH in setting the disposition of ProDUR edits that may vary by type of submission (e.g., real-time versus batch).
- Include situation-specific messaging and error codes for Drug Claims that reject because of ProDUR processing that enable the Network Provider to take appropriate actions.
- Establish edits that determine problems with a prescription and validate medical appropriateness of the prescribed drug by comparing the circumstances surrounding the request with established pharmacy-related therapeutic criteria.
- Ensure the ability to apply edits consistent with LDH requirements, regulatory changes, and innovations in ProDUR.
- Review Drug Claim requests against the following minimum potential ProDUR functions:
  - Potential drug over-utilization
  - Therapeutic duplication of drugs
  - Drug-allergy interactions and drug disease contraindications
  - Contraindication by Enrollee age and presumed or actual diagnosis from prior approved Drug Claims and other available data
  - Drug-to-drug interactions (with selectable severities)
  - Potential dosage error above or below therapeutic or cost-effective guidance
  - Potential drug abuse and/or misuse based on prior Drug Claims
  - Early refill conditions
  - Duration of therapy
  - Clinical misuse
  - Pregnancy precautions
- Automatically generate ProDUR messages in a manner that enables a Network Provider to cancel submission of the Drug Claim or, for messages that can be overridden, to submit the Drug Claim.

For reporting purposes, each of the following edits shall have its own separate denial code and description including, but not limited to, early refill, duration of therapy, therapeutic duplication, pregnancy precaution, quantity limit (excluding opioids), quantity limit for long-

acting opioids, quantity limit for short-acting opioids, diagnosis code required on selected agents, drug interactions, age limit, and dose limits. The Contractor shall align their coding of NCPDP compliant POS edits and overrides with LDH. PA is not an acceptable method to override certain POS edits.

Drug Claims processing shall be capable of capturing diagnosis codes at the POS and utilizing codes in the Adjudication process at POS. Denial of Drug Claims may be triggered by an inappropriate diagnosis code or the absence of a diagnosis code.

The Contractor's system shall:

- Allow Providers to enter responses utilizing NCPDP Professional Pharmacy Services (PPS) intervention codes in response to ProDUR messages as directed by LDH.
- Capture and store all NCPDP standard DUR conflict, intervention, and outcome messages for reporting to LDH and MCOs on encounters.
- Accommodate changes to the PPS intervention configuration as directed by LDH at no cost to LDH. Other NCPDP override fields may be appropriate in some prospective DUR initiatives upon approval of LDH.
- Have the capability to develop and deliver to the Drug Claim submitter new or revised ProDUR messages resulting from new and revised ProDUR criteria definitions.
- Maintain a set of parameters and variables applicable to ProDUR functionality that can be reviewed and approved by LDH. These are expected to minimally include:
    - Full or partial NDC code matching (including multiple NDC codes subject to potential drug/drug interaction)
    - Date of service
    - Product strength and quantity
    - Days' supply
    - Generic product identifiers
- Have the capability to screen for drug therapy concerns by specific drugs relative to high-risk disease, to include but not limited to:
    - Cardiovascular disease
    - Cerebrovascular disease
    - Central nervous system disease
    - Renal disease
    - Endocrine disease
    - Chronic pain syndromes
    - Substance use disorder
    - Gastrointestinal disease
    - Psychiatric disease
    - Respiratory disease

The MCOs and/or the Contractor may send proposed edits to LDH for consideration. When this happens the Contractor shall:

- Present ProDUR results to Network Providers in a format that supports their ability to advise and counsel Enrollees appropriately.

- Evaluate and return responses to ProDUR alert conditions, as directed by LDH.
- Allow for multiple dispositions for ProDUR alert types including, but not limited to, message only (educational), soft edit (deny and require reason for service and result of service codes or other pharmacist override) or hard edit (deny and require PA as directed by LDH).
- Allow for ProDUR alerts that fall within one interaction type (e.g., drug to drug level one interaction) to be uniquely dispositioned as in the previous requirement without changing the disposition of the edit in general (e.g., setting one specific level one drug to drug interaction to message only while all other level one drug to drug interactions is set to soft edit).
- Edit and Adjudicate for ProDUR alerts between single line-item Drug Claims and multi-ingredient compounds.
- Allow for posting of multiple ProDUR alerts in a single response to pharmacy.
- Allow for hierarchy of ProDUR alerts/edits, as approved by LDH, so that the response transaction lists the highest ranking ProDUR alert first, if there are multiple ProDUR alerts, and in a manner that enables a Network Provider to make appropriate decisions to reverse or correct the accepted Drug Claim or override a rejected Drug Claim.
- Assure the pharmacist offers to counsel the patient or caregiver. A log of receipt of prescription and the offer to counsel by the pharmacist shall be incorporated into its policy, Provider Agreements, and contracts with PSAOs.
- Comply with the SUPPORT Act by:
    - Following prospective safety edits for opioids including early, duplicate and quantity limits, as specified by the State.
    - Following maximum daily morphine milligram equivalents (MME) prospective safety edits, as specified by the State.
    - Following the State's clinical authorization criteria for monitoring and managing the appropriate use of antipsychotic medications by Enrollees under the age of twenty-one (21).
- Set the early refill edit on controlled drugs at ninety percent (90%) used. When an early refill message occurs, require a PA to override for controlled drugs.
- Provide reports and data annually to each MCO, as requested, for the CMS DUR annual report. The MCO must send the annual report to the State thirty (30) Calendar Days after CMS provides the link.

2.1.14 Provider and Enrollee Support

The Contractor shall deliver Provider and Enrollee customer service through multiple contact methods using trained technical and clinical staff. The primary source of inquiries is expected to be Network Providers seeking assistance with Drug Claim submission issues. The Contractor shall be prepared to receive Enrollee customer service calls directed from the Enrollees' MCO to assist with Network, drug coverage, and PA status questions. Customer service support shall also include Prescribers seeking more clinically oriented assistance with securing PA approvals and related status inquiries.

2.1.14.1 Customer Service Center (CSC)

The Contractor's service desk(s) shall provide support for all functions of the managed care pharmacy program, including but not limited to:

- POS Help Desk: Network Provider technical inquiries, available toll-free twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year to respond to questions on issues such as coverage, Drug Claims processing, Enrollee eligibility, and reimbursement.
- PA Help Desk: Prescriber inquiries of all types, available toll-free to receive and make a decision to approve or deny PA requests, as well as Appeals and Grievances regarding PA denials and/or processes. The PA help desk shall be a toll-free twenty-four (24) hours per day, seven (7) days per week call center, staffed with appropriate clinical personnel accessible 7:00 am to 7:00 pm Central Time, Monday through Friday, excluding agreed-upon holidays, except for downtime approved in advance by LDH.
- Enrollee Help Desk: Enrollee inquiries of all types, available toll-free to respond to inquiries from Enrollees on general pharmacy coverage, Network Provider locations, drug coverage, PA status or other Enrollee requests. The Enrollee help desk shall be staffed (live) from 7:00 am to 7:00 pm Central Time, Monday through Friday.

The Contractor shall:

- Establish and maintain a Customer Service Center (CSC) to serve as a point of contact to assist Prescribers, pharmacists, Beneficiaries, MCOs, Providers, and other parties with inquiries regarding the managed care pharmacy program.
- Create and maintain an email address for individuals to utilize for pharmacy related inquiries. All e-mails received shall be acknowledged within twenty-four (24) hours of receipt and resolved within three (3) Business Days unless otherwise approved by LDH.
- Provide accessibility to the CSC through toll-free help lines and electronic and other modes of communication, including, but not limited to phone, voicemail, email, web portal, fax, and mail. The Contractor may adopt new technology (e.g., text, mobile app, online chat) as directed by LDH.
- Locate its primary CSC site in the State.
- Provide access to a backup CSC that is not geographically located within 500 miles of the primary site to handle calls when there is weather related emergencies or other unexpected occurrences that may impact access to the primary CSC or ability to meet CSC standards in *CSC Performance Standards section*.
- Address inquiries regarding the Medicaid managed care pharmacy program, including, but not limited to, the following:
  - Drug Claims processing issues
  - PDL inquiries
  - PA requests and inquiries
  - Medicaid eligibility and MCO enrollment status
  - Network Provider reimbursement rates
  - Locating a Network Provider
  - Status of prescriptions and refills

  - Obtaining or understanding its policies and procedures
  - Website content and/or performance inquiries
  - Resolution of concerns, questions, and problems
  - Grievances and Appeals
  - Provider complaints
- Provide adequate training and access to information to route and facilitate timely and accurate responses to inquiries.
- Provide access to up-to-date information and data needed to address and resolve inquiries, including, but not limited to, individual information, Provider information, PA data, Drug Claims data, payment data, and LDH pharmacy policy and procedures.
- Provide search capabilities that speed access to needed information across systems through easy-to-use search and phonetic matching.
- Provide a current organizational chart with staff responsibilities and contact information for the CSC on a quarterly basis, or as changes occur.
- Implement and follow escalation workflows to ensure proper handling of inquiries, including referral to appropriate internal staff and external entities.
- Handle emergent Provider issues twenty-four (24) hours per day, seven (7) days per week.
- Record all incoming calls for quality assurance and/or training in a format that can be retrieved and audibly reviewed at a future time, including indexing and search capabilities.
- Retain call recordings in accordance with State and Federal requirements, for a period of no less than ten (10) years, unless otherwise directed by LDH.
- Provide an LDH approved quality and tracking process to ensure that all phone, email, and other correspondence received is answered in a prompt and professional manner and routed to the correct respondent.
- Handle emergent Provider issues twenty-four (24) hours per day, seven (7) days per week.

2.1.14.2 Outbound Campaigns

The Contractor shall support and perform LDH-directed and approved outbound campaigns (for reasons such as education on new initiatives, program changes, etc.) to individuals or Providers in different modes, including but not limited to calls, email, text, and fax. Upon such a request by LDH, the Contractor shall provide services including, but not limited to:

- Providing a written work plan within five (5) Calendar Days of the request and update the work plan as directed by LDH.
- Designing the outbound campaigns.
- Developing necessary scripts/content subject to LDH's prior written approval.
- Providing a listing of those individuals or Providers to be contacted.
- Executing the outbound campaign at the specified timeframes/intervals.
- Recording the outcome of the contact (e.g., person answered / listened for x minutes, no answer / voice mail message left, no answer / no voice mail message left, busy signal).

- Associating the record to the campaign and contacted party.
- Producing campaign outcome reports based on the campaign requirements, as approved by LDH.

2.1.14.3 CSC Quality Assurance

The Contractor's Customer Service Center shall have the capability to:

- Perform a quarterly self-audit of CSC inquiries to ensure inquiries were addressed appropriately, accurately, courteously, and timely, and in accordance with State and Federal requirements.
- Provide LDH and the MCOs with quarterly reports of the customer service center audit, including findings and any remediation activities.
- Ensure only LDH-approved phone scripts are used by customer service center staff.
- Provide designated LDH and MCO staff with access to its customer service center systems.
- Notify designated LDH and MCO staff of unscheduled downtime within thirty (30) minutes of the start of an incident occurrence.
- Document, categorize, process, and track all Drug Claim inquiries and Network Provider/Enrollee communications and complaints, Grievances and Appeals through an electronic tracking tool provided by the Contractor and available for unredacted review by LDH and the MCOs through on-line access.
- Maintain a searchable call log for one hundred percent (100%) of calls to document all contacts, including, but not limited to, CSC agent's identifier and date.
- Maintain call center services and call center lines to respond to Drug Claims inquiries, questions, problems, and complaints regarding operations, and for other Network Provider and Enrollee support. The Contractor shall supply all required information systems, telecommunications, and dedicated personnel to perform these operations.
- Provide customer service (Enrollee help desk) that is scalable to meet LDH's and the MCOs' future needs and includes, but is not limited to, the following:
    - Staffed (live) from 7:00 am to 7:00 pm Central Time, Monday through Friday.
    - A voice message system to receive calls outside of 7:00 am to 7:00 pm Central Time, Monday through Friday.
    - Capacity to handle all telephone calls including times of peak call volume and to meet the LDH's and MCOs' needs and performance expectations.
    - A process to document and ask callers whether they are satisfied with the response given to their call. If the caller is not satisfied, the Contractor must ensure that the call is referred to the appropriate individual for follow-up and/or resolution. This referral must take place within forty-eight (48) hours of the call.
    - Management tracking and reporting capabilities.
    - A Quality Assurance (QA) program that includes call sampling and follow up to confirm efficient handling and measure caller satisfaction.
    - Compliance with the LDH's requests, and MCOs' request with LDH approval, for records to review and audit both targeted and random sample Drug Claims and

documentation to ensure contractual requirements. All records and documentation shall be unredacted.

- Accurate and timely response to all caller inquiries and requests in all languages through Contractor staff and/or LDH-approved language translation services. This includes oral interpretation and the use of auxiliary aids such as Teletypewriter/Telecommunications Device for the Deaf (TTY/TDY), American Sign Language and assistance for individuals with limited English proficiency (LEP) in their primary language.

- Initiate Backup systems, infrastructure, and processes to ensure continuity of services.

Upon Contract termination, the Contractor shall release the toll-free phone numbers and email addresses used during the Contract to another vendor or to LDH for use during a subsequent contract at no additional cost to LDH or the subsequent contractor.

Table 5: Provider Pharmacy Calls

Month	Aetna	AmeriHealth	Healthy Blue	Louisiana HealthCare	United HealthCare
January	711	3555	1528	1822	678
February	535	2944	1097	1598	581
March	583	3549	1460	1668	667
April	549	3069	1442	1522	566
May	553	2530	1280	1586	505
June	538	2833	1315	1484	301

2.1.14.4 CSC Performance Standards

The Contractor's Customer Service Center shall meet the following performance standards for all help desks:

- Answer ninety-five percent (95%) of calls within thirty (30) seconds or direct the call to an automatic call pickup system with IVR options.
- No more than one percent (1%) of incoming calls receive a busy signal.
- Maintain an average hold time of three (3) minutes or less per call. Hold time, or wait time, includes 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, the measure of time when a customer service representative places a caller on hold.
- Maintain Abandoned Call rate of not more than five percent (5%).

2.1.15 Oversight and Monitoring

LDH shall provide oversight and monitoring of the Contractor's activities and operations as well as ensure effective collaboration between the Contractor and the MCOs. The Contractor will contract with LDH to enforce the terms and conditions laid out herein; however, LDH will not pay the Contractor directly for any services. All payments will be made under the contracts between the Contractor and the MCOs, and LDH shall not be a party to such contracts.

The MCO 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. The MCO shall approve and monitor implementation of the CAP through available reporting resources, on-site evaluations, or requested status reports. The CAP shall include a timeframe for anticipated compliance and a date certain for the correction of the non-compliance.

A CAP is not required before the MCO may pursue the application of any other non-compliance action authorized in the Contract, including, but not limited to, assessing penalties in accordance with the table of monetary penalties (Attachment V). Monetary Penalties shall continue until satisfactory correction of the non-compliance has been made as determined by the MCO.

The Contractor shall submit a written description of the assurances and procedures that shall be put in place, such as an independent audit, to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information. These assurances and procedures shall be transmitted to LDH for review and approval prior to the date pharmacy services begin.

2.1.16 On-Site Reviews

The MCOs, LDH, or LDH's designee may conduct on-site reviews at any time during the term of the Contract to monitor Contractor performance or assess compliance of any contractual requirement.

2.1.17 State and Federal Compliance

Compliance includes activities necessary for annual reporting and control activities, as well as compliance with State and Federal requirements. The Contractor shall comply with:

- All applicable State and Federal laws, rules, regulations, policies, procedures, and manuals, and the State Plan.
- Relevant standard and operating rule mandates for healthcare EDI, particularly those named in HIPAA, including those developed and published by X12, NCPDP, and Health Level Seven International (HL7).
- All current and future HIPAA standard Transactions and Code Sets (TCS) in place or mandated by LDH and CMS.
- State and Federal records management policies and retention schedules.
- All State and Federal audit requests.

The Contractor shall:

- Capture and maintain data necessary to meet all legal requirements (e.g., State, Federal, administrative).
- Provide LDH-authorized users access to Contractor facilities for the purposes of audit, review, or physical inspection of system assets and system security, network, and access to any project artifacts, and access to records including any records that are stored offsite, at no additional cost to LDH or the MCOs.

- Retain all records and reports relating to this agreement for a period based on LDH policy. When an audit, litigation, or other action involving or requiring access to records is initiated prior to the end of said period, however, records shall be maintained based on the LDH policy following resolution of such action, or longer if such action is still ongoing. Records shall be in a format admissible into evidence in any court of law.

2.1.18 Audit

The Contractor shall have an audit program that includes, at a minimum:

- The submission of policies of its audit program for approval by LDH.
- Coordination with LDH to develop an annual plan detailing the audit of Drug Claims including:
  - Audits of at least five percent (5%) of pharmacies enrolled in the network.
  - A strategy for conducting desk and onsite audits of Drug Claims.
  - Methods for coordinating audit and program integrity efforts with the LDH Program Integrity, Program Operations & Compliance, and Quality & Innovations sections.
  - Audits to determine Provider compliance with the program policies, procedures and limitations outlined in the Provider Agreement. The Contractor shall not utilize contingency-fee based pharmacy audits.

The Contractor's contracts with pharmacies for other lines of business or other contracts shall not limit its ability or the volume of audits it can perform of that pharmacy or any other pharmacy's Drug Claims. The Contractor shall:

- Request hard copy prescriptions and any related Drug Claim documentation from Network Providers within thirty (30) Calendar Days of end of quarter of identification of possible billing errors, as directed by LDH, if the Contractor is directed to audit a Network Provider.
- Utilize initial Drug Claim review request letters that clearly define the LDH rationale for identified overpayments, including a citation of the applicable statute, rule, regulation, or manual section as directed by LDH.
- Perform a desk or onsite Drug Claim review on an ad hoc basis, or if requested to do so by LDH.
- Develop a year-end Project Management Report detailing a brief review of the year's Drug Claim review activities broken out by Drug Claim review type. This report is due within forty-five (45) Calendar Days after the end of each calendar year or at a time that is agreeable to LDH. The report shall summarize, at a minimum:
  - Any policy and procedure changes the Contractor has implemented or suggested to LDH.
  - Number of Drug Claim reviews performed, potential recoupment, actual recoupment amounts, and number of open reconsiderations.

The Contractor shall:

- Ensure that its systems facilitate the auditing of individual Drug Claims. Adequate audit trails shall be provided throughout the systems.

- 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.
- 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.
- 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.
- Provide a Sampling of Paid Drug Claims.
  - 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:
    - Description of the service furnished.
    - The name of the Provider furnishing the service.
    - The date on which the service was furnished.
    - The amount of the payment made for the service.
    - The method for notifying the Contractor of services not rendered.
  - The Contractor shall stratify the paid Drug Claims sample to ensure that all Network Provider types and all Drug 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 scrutiny, the Contractor may over sample the group. The paid Drug Claims sample shall be a minimum of two percent (2%) of paid Drug Claims per month to be reported to LDH on a quarterly basis.
  - The notices may be provided by mail, telephonically, or in person (e.g., case management on-site visits).
  - 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 Enrollee education, Provider education, payment recovery, or referral to LDH. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.
  - 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.
  - 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.
- Process Payment Recoupments as follows:

- Provide prior written notification of its intent to recoup any payments to LDH for review and approval. Such notification shall include:
  - The Enrollee's name, date of birth, and Medicaid identification number.
  - The date(s) of health care services rendered.
  - A complete listing of the specific Drug Claims and amounts subject to the recoupment.
  - The specific reasons for making the recoupment for each of the Drug Claims subject to the recoupment.
  - The date the recoupment is proposed to be executed.
  - The mailing address or electronic mail address where a Provider may submit a written response.
  - When applicable, the date LDH notified the Contractor of the Enrollee's Disenrollment via the ASC X12N 834 Benefit Enrollment and Maintenance Transaction.
  - When applicable, the effective date of Disenrollment.
- If LDH determines that the recoupment is valid, the Contractor shall provide prior written notification to the Network Provider of its intent to recoup any payment, including the data elements listed above.
- 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.
- 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.
- 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.
- Transfer one hundred percent (100%) of its recoupments the appropriate MCO.
- Void encounters for Drug 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 Drug Claims.
- The Contractor must complete all reviews and/or audits of a Drug Claim no later than one (1) year after receipt of a Drug 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 Drug 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.

- This limitation does not apply in cases of Provider FWA that the Contractor did not discover within the one- (1)-year period following receipt of a Drug Claim via "complex" review.
- 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 Drug Claim.

- For Enrollees disenrolled due to the invalidation of a duplicate Medicaid ID, the Contractor shall not recover Drug Claim payments under the retroactively disenrolled Medicaid ID if the remaining, valid ID is also linked to the 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.
- The Contractor shall develop and implement a safeguard for automated reviews to prevent subsequent reviews on a Drug 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 Drug Claim for which an automated denial was reversed subsequent to Provider dispute, when the denials are for the same reason. For such Drug Claims, the Contractor shall ensure a complex review and consideration of the Drug Claim history or audit trail.
- At the Provider's request, the Contractor shall provide an independent review of Drug Claims that are the subject of an Adverse Benefit Determination by the Contractor. The review shall be provided and conducted in accordance with La. R.S. 46:460.81 through 460.90.
- The Contractor shall not recoup simply on the basis of an encounter being denied.

2.1.19 Fraud, Waste, and Abuse

2.1.19.1 General Provisions

The Contractor shall:

- Certify all statements, reports and Drug Claims, financial and otherwise, as true, accurate, and complete. The Contractor shall not submit for payment purposes those Drug 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.
- Have programs and procedures pursuant to 42 CFR §438.608(a)(1) to safeguard Louisiana Medicaid Program funds against unnecessary or inappropriate use of PBM 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 FWA activities.

- 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 FWA.
- Seek to reduce prospective financial loss when fraudulent and/or criminal activity is suspected through pre-payment or post-payment review, audit, or investigation. The Contractor may mitigate financial loss by employing procedures including, but not limited to, pre-payment edits, PA, medical necessity review, verification of services being rendered as billed, payment withhold in full or in part, Corrective Action Plans, termination of the Provider Agreement, or other remedies.
- Ensure that the Contract Compliance Officer and CEO or COO meet in person, unless otherwise approved by LDH in writing, with LDH and MFCU at LDH's request to discuss FWA, 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 FWA prevention.

The Contractor, Subcontractors, and Network Providers shall:

- Comply with all applicable Federal and State laws, regulations, rules, policies, procedures, and manuals relating to FWA in the Louisiana Medicaid Program, including, but not limited to, 42 CFR §§438.1 through 438.608; La. R.S. 46:437.1 through 437.14; 42 CFR §§455.12 through 455.23; LAC 50:I.4101 through 4235; and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.
- Cooperate and assist the State and any State or Federal agency charged with the duty of identifying, investigating, or prosecuting suspected FWA. 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 the Contractor or any Subcontractor or Network Provider during Business Hours, except under special circumstances determined by the MFCU when after-hours admission shall be allowed.
- 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.
- 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.
- Comply with all Federal requirements (42 CFR Part 1002) on exclusion and debarment screening. Any unallowable funds paid 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.

The Contractor, its employees, consultants, Subcontractors, and employees of Subcontractors shall cooperate fully and be available in person for interviews, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other investigative or judicial processes.

2.1.19.2 Fraud, Waste, and Abuse Compliance Plan

In accordance with 42 CFR §438.608(a), the Contractor and Subcontractors, to the extent that the Subcontractor is delegated responsibility by the Contractor for coverage of services and payment of Drug Claims under the Contract, shall implement and maintain a compliance program that includes arrangements and procedures designed to prevent and detect FWA.

The arrangements and procedures of the compliance program shall include all of the following elements:

- 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.
- 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.
- 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.
- A system for training and education for the Contract Compliance Officer, the organization's senior management, and the organization's employees for Federal and State standards and requirements under the Contract. Such training shall include, but not be limited to:
  - Annual training of all employees.
  - New hire training within thirty (30) Calendar Days of beginning date of employment.
- Requirement that new employees 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.
  - FWA 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).
  - 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.

- Effective lines of communication between the Contract Compliance Officer and the organization's employees.
- Enforcement of standards through well-publicized disciplinary guidelines.
- 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.
- Procedures for prompt notification to LDH when information is received about changes in an Enrollee's circumstance that may affect the Enrollee's eligibility for the Louisiana Medicaid Program including changes in the Enrollee's residence and death of an Enrollee.
- Procedures for prompt notification to LDH when the information is received about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the Louisiana Medicaid Program.
- 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.
- Provision for the 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.
- Procedures for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract.
- Protections to ensure that no individual who reports program integrity related violations or suspected FWA 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.
- 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.
- Procedures for prompt reporting to the State of all overpayments identified and recovered, specifying the overpayments due to potential Fraud.
- Detection and prevention of Louisiana Medicaid Program violations and possible FWA overpayments through data matching, trending, statistical analysis, monitoring service and billing patterns, monitoring Drug Claims edits, and other data mining techniques.

- Descriptions of specific controls in place for prevention and detection of potential or suspected FWA, including: lists of pre-payment Drug Claims edits, post-payment Drug Claims edits, post-payment Drug Claims audit projects, data mining and Provider profiling algorithms, and references in Provider and Enrollee materials relative to identifying and reporting Fraud to the Contractor and law enforcement.
- 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.
- 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.
- 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, employees of the Contractor, Subcontractors, employees of Subcontractors, and the public on the Contractor's website required under the Contract. The Contractor shall implement procedures to review complaints filed in the Fraud reporting email account at least weekly, and investigate and act on such complaints as warranted. The Contractor shall submit to LDH or its designee the FWA 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.

2.1.19.3 Identification, Investigation, and Referral of Suspected Fraud and Abuse

The Contractor shall:

- Have methods for identification, investigation, and referral of suspected Fraud and Abuse cases (42 CFR §455.13, §455.14, and §455.21) both internally and for Providers and Subcontractors.
- Report all tips regarding suspected or confirmed Fraud and/or Abuse to LDH and the appropriate law enforcement agency as follows:
    - All tips regarding any potential billing or Drug Claims issue identified through either complaints or internal review received within the previous month shall be reported to LDH Program Integrity monthly.
    - Triage and/or substantiate tips and provide updates to MFCU and LDH when the concerns and/or allegations of any tips are authenticated.
    - Suspected Fraud and/or Abuse in the administration of the program shall be reported in writing to LDH Program Integrity and MFCU within five (5) Business Days of the Contractor becoming aware of the issue.
    - All confirmed or suspected Provider Fraud and/or Abuse shall immediately be reported in writing to LDH Program Integrity and MFCU.
    - All confirmed or suspected Enrollee Fraud and/or Abuse shall be reported immediately, in writing, to LDH Program Integrity and local law enforcement of the Enrollee's parish of residence.

- Utilize the LDH Provider Fraud Referral Form available in the MCO Manual when making a referral of confirmed or suspected Fraud and/or Abuse.
- Promptly perform a preliminary investigation of all incidents of suspected Fraud and/or Abuse. After reporting suspected or confirmed Fraud and/or Abuse, unless prior written approval is obtained from the agency to whom the incident was reported, the Contractor shall not take any of the following actions as they specifically relate to Drug Claims:
  - Contact the subject of the investigation about any matters related to the investigation.
  - Enter into or attempt to negotiate any settlement or agreement regarding the incident.
  - Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
- 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.
- Suspend payment to a 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 Provider pending the investigation. The Contractor is responsible for sending the Provider the required notice and Appeal rights as required by 42 CFR §455.23.

2.1.19.4 Reporting

Reporting shall include, but is not limited to, the following, as set forth at 42 CFR §455.17:

- Number of complaints of FWA, neglect, and overpayments made to the Contractor that warrant preliminary investigation (under 42 CFR §455.14).
- Number of complaints reported to the Contract Compliance Officer.
- 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:
  - Provider Name and ID number.
  - Source of complaint.
  - Type of Provider.
  - Nature of complaint.
  - Approximate amount of dollars involved if applicable.
  - Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.

The Contractor shall report the following information to each MCO:

- All audits performed and overpayments identified and recovered each month by the Contractor and Subcontractors. [See 42 CFR §438.608(d)(3).]
- Overpayments made by the MCO to the Contractor within sixty (60) Calendar Days from the date the overpayment was identified.

- All unsolicited Provider refunds received each month, including any payments submitted to the Contractor and/or Subcontractors by Providers for overpayments identified through self-audit and/or self-disclosure.

2.1.20 Rights of Review and Recovery by Contractor and LDH

The Contractor shall:

- Have the right to audit, review, and investigate Network Providers and Enrollees for a one (1) year period from the date of payment of a Drug Claim via "automated" review. An automated review is one for which an analysis of the paid Drug 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.
- Not recover from Providers via automated review for Drug Claims older than one (1) year unless authorized in writing by LDH. All recoveries shall be prior approved by LDH.
- Transfer one hundred percent (100%) of its recoveries the appropriate MCO.
- Void encounters for Drug 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 Drug Claims.
- Have the right to audit, review and investigate Network Providers and Enrollees for a five (5) year period from the DOS of a Drug 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 Contractor must ensure that all recoveries are accurately reflected in Drug Claims and encounters for rate setting purposes, thereby "returning" the overpayment to LDH.
    - 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.
- Ensure compliance with all requirements of La. R.S. 46:460.72-460.73, including the requirement to void all Drug Claims and encounters associated with FWA 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.

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 Drug Claims upon which the recoupment or withhold are based meet one (1) or more of the following criteria:

- 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.

- When the issues, services, or Drug Claims that are the basis of the recoupment or withhold are the subject of pending State or Federal investigation, audit, and/or lawsuit.

Such prohibition shall be limited to a specific Provider(s), for specific dates, and for specific issues, services, or Drug Claims. In the event that the Contractor obtains funds in cases where recovery, recoupment, or withhold is prohibited, LDH may recover the funds from the Contractor.

Contact with a Provider shall be prohibited in instances resulting from suspected or confirmed Fraud and/or Abuse that the Contractor has identified and submitted a referral of Fraud to LDH and MFCU or other appropriate law enforcement agency, until approved by LDH in writing.

If the Contractor fails to collect at least a portion of an identified recovery within three hundred sixty-five (365) Calendar Days from the date LDH approved proceeding with the recoupment, 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 designee may recover the overpayment from the Provider 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 the Provider Agreement with the Provider, or dissolution of the Provider's business.

LDH or its designee shall have the right to audit, review, and investigate Network Providers and Enrollees via "complex" or "automated" review. LDH shall not initiate its own review of the same Drug Claims for a Network Provider that has been identified by the Contractor as under a review approved by LDH. LDH shall track open LDH and Contractor reviews to ensure audit coordination.

The MCOs shall have the right to audit, review, and investigate their Enrollees and MCO Network Providers via "complex" or "automated" review. An MCO may recover from the Contractor, via a deduction from the Contractor's payment, any Provider overpayments identified by the MCO. The Contractor may pursue recovery from the Provider as a result of the MCO-identified overpayment.

In the event LDH or its designee 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 DOS under review, and amount paid. The Contractor shall have ten (10) Business Days to indicate whether the Drug Claims were corrected or adjusted prior to the date of the notification from LDH. If LDH does not receive a response from the Contractor within ten (10) Business Days, LDH may proceed with its review.

In the event LDH or its designee investigates, reviews, or audits a Network Provider or Enrollee, the Contractor shall comply with document and Drug Claims requests from LDH or its designee

within fourteen (14) Calendar Days of the request, unless another time period is agreed to in writing by the Contractor and LDH or its designee.

LDH shall notify the Contractor and the Network Provider concurrently of overpayments identified by the State or its designee.

Upon the conclusion of Provider rebuttals and Appeals, if applicable, LDH or its designee shall notify the Contractor of the overpayment. The Contractor shall correct or initiate its own review on the identified encounters within fourteen (14) Calendar Days of notification from LDH. The Contractor shall submit confirmation that the corrections have been completed.

There shall be no Provider improper payment recovery request of the Contractor applicable for the dates of service occurring before the Operational Start Date or for Providers that are not in the Network.

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.

2.1.21 Prohibited Affiliations

In accordance with 42 CFR §438.610, the Contractor and Subcontractors are prohibited from knowingly having a relationship with:

- 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.
- An individual or entity that is excluded from participation in any Federal health care program under 42 USC §1320a-7 and §1320a-7a.

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:

- An individual convicted of crimes described in 42 USC §1320a-7(b)(8)(B).
- 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.
- Any individual or entity that is excluded from participation in any Federal health care program under 42 USC §1320a-7 and §1320a-7a.

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:

- 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.
- Any individual or entity that is excluded from participation in any Federal health care program under 42 USC §1320a-7 and §1320a-7a.
- 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.
- 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 USC §1320a-7 and §1320a-7a.

The Contractor is prohibited from being controlled by a sanctioned individual under 42 USC §1320a-7(b)(8).

If LDH finds the Contractor is not in compliance with 42 CFR §438.610(a) and (b), LDH:

- Shall notify the Secretary of the U.S. Department of Health and Human Services (HHS) of the noncompliance.
- May continue an existing agreement with the Contractor unless the Secretary of HHS directs otherwise.
- 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.
- Nothing in this section shall be construed to limit or otherwise affect any remedies available to the U.S. under 42 USC §1320a-7, §1320a-7a, and §1320a-7b.

The Contractor and 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. The Contractor and its Subcontractors shall screen all employees, contractors, and Network Providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any Federal health care programs. To help make this determination, the Contractor shall conduct screenings to comply with the requirements set forth at 42 CFR §455.436.

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 USC §1320a-7a(a)(6) and 42 CFR §1003.102(a)(2).]

An individual who is an Affiliate of a prohibited person or entity described above can include:

- A director, officer, or partner of the Contractor.
- A Subcontractor.
- 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 the Contract.
- A Network Provider.

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 its employee, Network Provider, Subcontractor, or employee of a Subcontractor under the provisions of 42 USC §§1320a through 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.
- Report to LDH, within three (3) Business Days, when it has discovered that its employee, Network Provider, Subcontractor, or employee of a Subcontractor has been excluded, suspended, or debarred from any state or Federal health care benefit program via the designated LDH Program Integrity contact.

The Contractor, through its Contract Compliance Officer, shall attest monthly to LDH that it has screened all employees and Subcontractors as specified in the Debarment/Suspension/Exclusion section to capture all exclusions.

The Contractor and 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.

2.1.22 Program Integrity Requirements

The Contractor shall:

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

- 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.
- 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.

2.1.23 Security and Privacy

The Contractor shall:

- Comply with all Federal and State privacy and data security requirements.
- Develop and implement written policies and procedures that restrict the use and disclosure of Louisiana Medicaid Program data, including, but not limited to, Protected Health Information (PHI), Personally Identifiable Information (PII), State Sensitive Information (SSI), and other information concerning Enrollees to purposes directly connected with the performance of the requirements in the Contract.
- Establish and maintain physical, technical, and administrative safeguards to prevent unauthorized access to PHI, PII, and SSI.
- Encrypt Louisiana Medicaid Program data to FIPS 140-2 standards when at rest or in transit.
- Ensure that Contractor owned resources are 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).
- Comply with all regulatory requirements that would apply to the State, when required to carry out an obligation of the State under 45 CFR Part 164, Subpart E.
- Provide network connectivity for the LDH-approved personnel at its offices and facilities during the term of the Contract, at the Contractor's expense. This can be secure guest Wi-Fi or some other LDH-approved method.
- Comply and cooperate with any HIPAA privacy related requests.
- Determine, report, and respond to any actual, attempted, or suspected theft of, accidental disclosure of, loss of, or inability to account for any PHI, PII, or SSI.

To ensure compliance with Privacy requirements, the Contractor shall:

- Cooperate with any attempt by LDH to monitor the Contractor's compliance as requested by LDH.
- Comply with data handling privacy requirements associated with HIPAA and as further defined by The United States Department of Health and Human Services Privacy Requirements, when handling confidential employee or citizen data associated with PHI and/or PII.
- Provide the capability to restrict distribution of data and information that is deemed sensitive, confidential, or personal (e.g., PHI/PII/SSI) in situations where it would normally be distributed, based on LDH-defined business rules.

- Comply with all applicable State and Federal requirements, including, but not limited to, La. R.S. 40:1165.1, La. R.S. 13:3734, La. R.S. 46:56, 45 CFR Parts 160 through 164, and 42 CFR §431.300, §431.302, §431.305, and §431.306.
- Ensure PHI/PII/SSI is not used or disclosed except as authorized by LDH or as otherwise required under HIPAA regulations, State and Federal Medicaid confidentiality requirements, and any other applicable State or Federal requirements.
- Implement safeguards and comply with Subpart C of 45 CFR Part 164 pertaining to electronic PHI/PII/SSI to prevent the impermissible use or disclosure of PHI/PII/SSI on paper or electronic Drug Claims.
- Report to LDH any inappropriate use or disclosure of PHI/PII/SSI, in accordance with applicable State and Federal requirements.
    - Detail the process that shall be used to meet reporting requirements for inappropriate use or disclosure of PHI/PII/SSI.
- Report to LDH any breaches of unsecured PHI/PII/SSI as required in 45 CFR §164.410, in accordance with applicable State and Federal requirements.
    - Detail the process that shall be used to meet this requirement in compliance with NIST SP 800-61.
    - Report to LDH any security incident wherein the Contractor has knowledge or reasonably shall have knowledge under the circumstances, in accordance with applicable State and Federal requirements.
    - Obtain and provide to LDH a written agreement from all of its agents and Subcontractors that create, receive, maintain, or transmit PHI/PII/SSI from or on behalf of the Contractor, stating their compliance with 45 CFR §164.502(e)(1) and §164.308(b), as applicable.
    - Make available to LDH such information as LDH may require to fulfill its obligations to provide access to or provide a copy of any information or documents with respect to PHI/PII/SSI pursuant to HIPAA and regulations promulgated pursuant thereto, including, but not limited to, 45 CFR §164.524 and §164.528 and any amendments thereof.
    - Make any amendments to PHI/PII/SSI as directed, or agreed to, by LDH pursuant to 45 CFR §164.526, or take other steps as necessary to satisfy LDH's obligations thereunder. In the event that the Contractor receives a request for amendment directly from an individual, agent, or Subcontractor, the Contractor shall immediately notify LDH prior to making any such amendment(s) and shall only make such amendments upon the approval of LDH at its sole discretion and authority. Absent such express written authority, Contractor shall not make any such amendments to PHI/PII/SSI. The Contractor's authority to amend information is explicitly limited to information created by the Contractor.
    - Cooperate with LDH in responding to any HIPAA privacy related requests.
    - Make available to LDH and the Secretary of the U.S. Department of Health and Human Services any and all internal practices, documentation, books, and records related to the use and disclosure of PHI/PII/SSI received from LDH or PHI/PII/SSI created or

received on behalf of LDH. Such access is for the purposes of determining compliance with the HIPAA Rules.

- Provide the ability to identify information as confidential (e.g., PHI/PII/SSI), and only make it accessible to authorized users.
- Ensure that all data considered to be PHI/PII/SSI is secured while in transit and at rest (via encryption or an industry standard method of secure file transport).
- Ensure that any published electronic or printed documentation, (e.g., systems, user, training), does not contain any PHI/PII/SSI.
- Cooperate with LDH in responding to all privacy related requests dealing with the rights of the individual under the HIPAA regulations.

The Contractor's system shall inform a user of the applicable privacy policy and terms of service prior to granting access.

2.1.24 Reporting and Quality Assurance

The Contractor shall implement a regular and timely evaluation of its systems and processes to promote accuracy and quality. This evaluation includes a methodology of continuous improvement for the identification of incorrect and inappropriate Adjudication results stemming from Provider error, incorrect system configuration, and intentional FWA.

The Contractor shall be capable of transmitting all data that 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.

Along with the periodic review of Drug Claim submissions performed to identify unintended errors, an effort shall be made to cooperatively work with the Provider to adjust the Drug Claim and its payment to match the actual prescribed and dispensed product, quantity, and other relevant data.

Clinical reviews shall also be executed to promote collaborative and innovative management of the pharmacy benefit and enhanced outcomes for Enrollees, requiring the Contractor's staff to work along with LDH and MCO clinical staff as they cooperatively analyze pharmacy benefit coverage and decisions. Monthly reports shall be delivered to LDH and the MCOs ten (10) Business Days after the end of the month.

The Contractor shall develop and maintain systems and processes to thoroughly review and report upon the following aspects of Drug Claims review:

- Internal quality assurance and continuous improvement of its operations.
- Periodic review of Drug Claims submissions to identify errors, whether intentional or not, that shall be corrected to adjust the Drug Claim and its payment to match the actual prescribed and dispensed product, quantity, and other relevant data.

The Contractor shall:

- Provide a robust reporting package based on specifications provided by LDH and the MCOs.
- Utilize standard and ad hoc reporting solutions to support timely access to accurate data, ongoing program analytics, and predictive modeling activities.
- Accommodate new reports or modifications to existing reports at the request of the MCOs and LDH, at no additional cost.
- Ensure the Drug Claims summary report is timely, accurate, and complete.
- Produce specific reports as required by applicable State and Federal requirements, including, but not limited to, reporting to qualify for the appropriate levels of Federal matching funds.
- Deliver reports with content and in a format and schedule approved by LDH (e.g., record selection, field inclusion, sort, grouping) and that can be available electronically in a format that can be downloaded and manipulated easily (e.g., Microsoft Excel).
- Deliver standing and ad hoc reports that are correct, complete, and comply with Contract requirements.
- Provide a secure web-based report repository or equivalent where all reports are stored in an organized manner and easily accessed online by the MCOs and LDH staff to view, print, copy, and download.
- Provide functionality to produce reports for LDH's current (or future) program categories and other coverage groups or Drug Claim types (e.g., programs, batch claim submitter, e-prescriptions/ compounds/ home infusion claims, and eligibility data elements such as Enrollee age grouping, eligibility category, etc.).
- Comply with all LDH and MCO data requests and reports, such as, the Annual CMS DUR Report, the CMS-64 report, reports required by the Louisiana legislature, drug rebate processing, retroactive drug utilization reporting, program integrity functions, CMS T-MSIS reporting and other ad hoc reports.
- Develop, deliver, and execute a QA Plan, subject to LDH's approval, within thirty (30) Calendar Days of contract effective date. Minimally, this plan shall include quality oversight, monitoring, and monthly reporting on the Contractor's activities. These reports shall clearly demonstrate the Contractor's compliance with contract requirements and performance guarantees with attention to continuous quality improvement. The QA Plan shall be updated on an annual basis or more frequently if requested by LDH.
- Provide a monthly performance status report that includes:
  - Activities and operational statistics.
  - Issues and recommendations regarding current policies, procedures, and focus areas.
  - Top 100 prescriptions paid by dollar amount, therapeutic class, and by drug entity (name, form, and strength).
  - Provide data for all LDH monthly and quarterly reporting requirements.
- Develop and maintain, on a quarterly basis, an LDH-approved non-proprietary Drug Claim processing and procedure manual to be published on the Louisiana Medicaid website, MCO website and on the Contractor's website as a Provider reference. This manual shall explain how to bill Drug Claims for proper reimbursement.

- Assign a resource to analyze probable erroneous payments/Drug Claims processing errors within one (1) Business Day of being brought to LDH's attention by Providers, identified through the Contractor's quality process, pharmacy audit, or any other source.
- Recommend changes to LDH to clarify policy, add edits or other Drug Claims processing controls as issues are identified through Drug Claim review.
- Recommend to LDH changes that can prevent payments to Providers that are inconsistent with Medicaid policies or accepted standards of practice.
- Identify Drug Claims subjected to audit and recovery functions.
- Provide LDH, on a quarterly basis and in a format as required by LDH, a report detailing the results of contacts of Network Providers where Drug Claims data appeared questionable.
- Conduct and report a quarterly systematic review of all paid Drug Claims to identify and determine overpayments.
- Implement a high-dollar Drug Claim review process for high-cost Specialty Drugs or other therapies as directed by LDH, including Zolgensma and other high cost, low utilization Drug Claims and gene therapies.
- Conduct daily systematic review no later than one (1) Business Day after Adjudication to identify and determine inaccurate Drug Claims processing. The Contractor shall send notification within one (1) Business Day to the Provider that includes the error found in next day review, the reason the Drug Claim was determined to be in error, how to reverse and/or re-submit the Drug Claim and suggestions to prevent the error in the future. Subsequent follow up and documentation shall be presented to LDH for approval.
- Provide the capability to perform or participate in onsite reviews of pharmacies, utilizing a process and timeline mutually agreed upon by the Contractor and LDH.
- Produce all operational reports necessary to facilitate comprehensive oversight by LDH, including summary "dashboards" that show current and trending activities within the system.
- Present data, including configurable dashboards and key aggregated current and historical operational data for analysis.
- Provide the capability to report unduplicated data, based on LDH-defined criteria (e.g., days' supply, units, Enrollees, Providers).
- Produce a monthly executive level dashboard summary report for Drug Claims processed to be delivered to LDH ten (10) Business Days from the end of the previous month.
- Produce a monthly report for all Drug Claims paid for Specialty Drugs. This report shall include a breakdown of drugs dispensed and shall be broken down by LDH-identified criteria.
- Produce a monthly report for all Drug Claims processed under the 340B program to ensure compliance with the LDH 340B policy.
- Provide a monthly report summarizing TPL/dual eligible Drug Claims, identified at the point of sale, either through TPL codes submitted on the Drug Claim or via eligibility file or real-time TPL identification software.
- Produce a monthly report detailing morphine milligram equivalents (MME) which reports any Enrollees who are potential outliers and exceed the MME recommendations.

- Require the COO or designee to provide attestation and review all reports before they are submitted to LDH. The COO shall carefully and fully review the report and determine it to be free of errors and correct for its intended purpose.
- Produce a monthly ProDUR summary report with LDH-approved content (e.g., the reason for service code broken down by severity, count, and amount paid).
- Produce a monthly ProDUR paid savings report with LDH-approved content (e.g., Drug Claim detail for ProDUR related reversals and associated savings).
- Create a PDL Quarterly Operations Report that shall include at a minimum: PA approval and denial statistics related to PDL classes and non-PDL drugs, most common reasons for denial of each class, statistics related to PDL compliance in each class, utilization and costs statistics related to the drugs in each PDL class, and any other information requested by LDH. The Contractor shall provide the PDL Quarterly Operations Report within thirty (30) Calendar Days of the end of the quarter.
- Provide recommendations for drugs and/or drug classes to be added to the automated pharmacy PA tool, and pre-analysis and post-analysis data and ProDUR recommendations.
- Provide reports that clearly show trends over time, highlighting any identified problem areas in terms of both cost and volume.
- Provide reports that include the rates paid for drugs to the pharmacies and confirmation that the Contractor did not receive any rebates or other discounts related to drugs.
- Develop a robust peer-to-peer counseling program to oversee drug therapy, improve Enrollee care and support DUR activities.
- Provide peer-based profiling to alert Prescribers of their ranking within their specialty.
- On a monthly basis, the Contractor shall submit a Drug 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 Drug Claims management, and shall utilize a randomly selected sample of all processed and paid Drug Claims upon initial submission in each month. A minimum sample consisting of two hundred (200) to two hundred fifty (250) Drug Claims per month, based on financial stratification, shall be selected from the entire population of electronic and paper Drug Claims processed or paid upon initial submission.
    - The minimum attributes to be tested for each Drug Claim selected shall include:
        - Drug Claim data is correctly entered into the Drug Claims processing system.
        - Drug Claim is associated with the correct Provider.
        - Proper authorization was obtained for the service.
        - Enrollee eligibility at processing date was correctly applied.
        - Allowed payment amount agrees with contracted rate.
        - Duplicate payment of the same Drug Claim has not occurred.
        - Denial reason is applied appropriately.
        - Co-payments are considered and applied, if applicable.
        - Effect of modifier codes were correctly applied.
        - Proper coding.
    - The results of testing at a minimum should be documented to include:
        - Results for each attribute tested for each Drug Claim selected.

- Amount of overpayment or underpayment for each Drug Claim processed or paid in error.
- Explanation of the erroneous processing for each Drug Claim processed or paid in error.
- Determination if the error is the result of a keying error or the result of error in the configuration or table maintenance of the Drug Claims processing system.
- Drug Claims processed or paid in error have been corrected.

2.1.25 Emergency and Disaster Planning

In the event of an emergency, as determined by LDH, LDH shall have the authority to require the Contractor to implement any necessary configuration modifications to pharmacy requirements within seventy-two (72) hours of notification.

Within twenty-four (24) hours from LDH's request, the Contractor shall alter or remove Point of Sale, PA, or other pharmacy requirements as determined by LDH, in a manner that may be Statewide or limited to certain ZIP codes or parishes. For an emergency, specific changes shall be determined by LDH and may include:

- Point of Sale Edits, including, but not limited to, altering early refill and refill too soon edits to an educational alert (message to pharmacy only, no denial at Point of Sale) or altering early refill and refill too soon edits set to deny so that they return an override code to be utilized by the pharmacy if needed to bypass the edit, without the requirement of a phone call to the helpdesk.
- Prior Authorization requirements, including, but not limited to, altering PA denials to an educational alert (message to pharmacy only, no denial at Point of Sale) as well as extending the expiration date of currently approved PA to a date requested by LDH.
- Quantity limitation, including, but not limited to, allowing dispensing of a ninety (90) Calendar Day supply for medications specified by LDH.
- Copays, including, but not limited to, waiving Enrollee copays for Drug Claims. Copayment amounts shall be added back to the pharmacy reimbursement.
- Signatures, including, but not limited to, removing the requirement of a signature for pick-up or delivery.
- Lock-In restrictions, including, but not limited to, removing pharmacy Lock-In restrictions or both pharmacy and Prescriber lock-in restrictions including on a case-by-case basis.
- Any other change LDH deems necessary to respond to the emergency and protect Enrollee's health.

2.1.26 Continuity of Operations Plan

The Contractor shall develop and maintain a Continuity of Operations Plan (COOP) that addresses how the Contractor and any 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 Scope of Work. The COOP shall be invoked no later than when the fulfillment of these requirements is impacted by such an event.

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.
- Have a method for ensuring that PAs are extended and transferred to new Providers during a pandemic, natural disaster, man-made emergency, or other event if directed by LDH.
- Submit the COOP 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.
- Immediately inform LDH, in writing, when invoking its COOP. If the nature of the triggering event renders written notification impossible, the Contractor shall notify LDH of the invocation of the COOP 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 COOP as soon as possible.

2.1.26.1 Systems Contingency Plan

As part of the COOP, the Contractor shall provide a Systems Contingency Plan (SCP), 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. Core eligibility/enrollment and Drug Claims processing shall be restored within seventy-two (72) hours of declared major failure or disaster.

The SCP shall include, at a minimum, a disaster recovery plan (DRP) designed to recover systems, networks, workstations, applications, etc. in the event of a disaster; and a Business Continuity Plan (BCP) for restoring the operational function of the organization in the event of a disaster that includes items related to IT, as well as operational items such as employee notification processes and the procurement of office supplies needed to do business in the emergency mode operation environment.

The SCP shall address the following scenarios, at a minimum:

- The central computer installation and resident software are destroyed or damaged.
- 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.
- 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.
- 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.

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

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.

2.1.27 Written Materials

All written Enrollee materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.), shall:

- Comply with 42 CFR §438.10, 42 USC §1396u-2(d)(2)(A)(i), and 42 USC §1396u-2(a)(5).
- Be in a style and reading level that shall accommodate the reading skills of 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.
  - Other computer generated readability indices accepted by LDH.

  LDH reserves the right to require evidence that written materials for Enrollees have been tested against the 6.9 grade reading-level standard.

- Be clearly legible with a minimum font size of twelve (12)-point, with the exception of Pharmacy ID cards, and or otherwise approved by LDH in writing.
- Use materials of the same quality as the materials used for printed materials for the Contractor's commercial plans, if applicable.
- If a person making a testimonial or endorsement for the Contractor has a financial interest in the company, include a disclosure of same.
- Prominently display the Contractor's name, mailing address (and physical location, if different), website, and toll-free number on at least one (1) page within all multi-paged Enrollee materials.
- 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 in all multi-paged Enrollee materials.

- Be provided in alternative forms for persons with visual, hearing, speech, physical or developmental disabilities upon request. These alternative forms shall be provided at no expense to the Enrollee.
- 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.
- Be equitably distributed without bias toward or against any group.
- Accurately reflect general information, which is applicable to the average Enrollee of the Contractor.
- Include the following information:
  - The date of issue;
  - The date of revision; and/or
  - If the prior versions are obsolete.

Except as otherwise indicated in the MCO Marketing and Member Education Companion Guide, the Contractor may develop their own materials that adhere to requirements set forth in the Contract or use State developed model Enrollee notices. State developed model notices must be used for denial notices and pharmacy lock-in notices.

The Contractor shall submit Marketing and Enrollee Education materials for LDH 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.

Enrollees shall have free access to any Network Provider (except in cases where the Enrollee is participating in the pharmacy/Prescriber lock-in program). Neither the Contractor nor any Subcontractor is allowed to steer Enrollees to certain Network Providers including Specialty Pharmacies. LDH retains the discretion to deny the use of marketing and Enrollee material that it deems to promote undue patient steering, including, but not limited to, Enrollee web portals and mobile-based Enrollee applications.

Co-branded marketing materials shall be submitted to LDH by the Contractor for approval in writing prior to distribution, in accordance with the applicable processes and timelines.

2.1.28 Lock-In Program

Lock-In shall be utilized when LDH, an MCO, or the Contractor finds that an Enrollee has utilized services covered under the Louisiana Medicaid Program at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines. The Enrollee may be restricted for a reasonable period to obtain PBM Covered Services from designated Network Providers only, in accordance with 42 CFR §431.54(e). The following two types of lock-in shall be utilized:

- Pharmacy-Prescriber Lock-In: The Enrollee is allowed one primary care physician and up to three specialists if needed, one Network Provider, and a Specialty Pharmacy if needed.
- Pharmacy Only Lock-In: The Enrollee is allowed only one Network Provider to fill all his/her prescriptions.

On a periodic basis, LDH, LDH's designee, the MCO, or the Contractor shall select and generate an Enrollee list for the lock-in program based on established criteria. The MCO shall notify potential lock-in Enrollees of its intent to lock Enrollees into a limited number of Providers. The MCO shall grant Appeal rights to the Enrollees in accordance with Federal regulations.

Each MCO may lock-in additional Enrollees based on their own independent review, clinical criteria, or referral.

Regardless of the Enrollee's movement between MCOs, the Enrollee shall remain in lock-in status until the established termination lock-in period has expired.

2.1.28.1 Drug Claims Processing for Lock-In

The Contractor shall:

- Ensure correct Drug Claims processing for Enrollees in the Lock-In Program utilizing up to six potential fields for Prescriber and Network Provider linkages. The list of approved Prescribers and Network Providers shall be date driven and compared to the DOS of the Drug Claim or other date(s) as directed by LDH. Appropriate messaging back to the submitting Network Provider shall be consistent with NCPDP edits created for that purpose along with custom messaging, if directed to do so by LDH.
- Have Point of Sale denials to restrict Enrollees to the lock-in Network Provider and/or Prescriber(s).
- Allow an emergency supply of medication to be filled by a Provider other than the lock-in Network Provider to ensure access to necessary medication. Emergency fills may be subject to audit.
- Notify the enrollment broker and Providers of Lock-In status.
- Utilize the LDH template lock-in letters for the Enrollee, Network Provider and/or Prescriber.
- Be responsible for notifying the Enrollee, chosen Network Provider, and/or chosen Prescriber of the proposed lock-in status.
- Give the Enrollee notice and an opportunity for a State Fair Hearing, in accordance with procedures established by LDH and 42 CFR §431.54(e), before imposing the restrictions.
- Ensure the Enrollee has reasonable access, considering geographical location and travel time, to quality services under the Louisiana Medicaid Program.

2.1.29 Electronic Messaging

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.

As needed, the Contractor shall be able to communicate with LDH over a secure Virtual Private Network (VPN).

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.

2.1.30 Transition/Turnover Phase

Within one hundred eighty (180) Calendar Days of contract effective date, the Contractor shall develop an LDH approved Turnover Plan. The Turnover Plan shall be updated upon LDH's direction and within six (6) months of the end of the contract. The Turnover Plan shall be comprehensive detailing the proposed schedule, activities, and resource requirements associated with turnover tasks.

The Contractor shall turnover all completed Contract deliverable work including all working documents, in accordance with the LDH approved Turnover Plan. Activities include, but are not limited to maintenance of system files, software, and hardware; correction of system problems and deficiencies; and system modifications as necessary to accommodate LDH's needs without additional cost to LDH.

2.1.30.1 General Turnover Requirements

Upon termination of the Contract, the Contractor shall:

- Comply with all terms and conditions stipulated in the Contract, including but not limited to:
  - Continuation of PBM Covered Services to Enrollees until the effective date of termination.
  - Compliance with all requirements that survive termination of the Contract (e.g., Provider reimbursement, prior authorizations, 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.
- Promptly supply all information necessary for the reimbursement of any outstanding Drug Claims.
- 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.
- 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:
  - Staffing plan and retention strategies.
  - Continuity of care.
  - Enrollee support and communication strategies.
  - Provider network and access to care standards.
  - Provider support and communication strategies.
  - Drug Claims management, including Provider payments and recoupments.
  - Reporting of deliverables due after contract termination.
  - Monitoring and quality assurance processes.

- 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.
- Address the turnover of records and information maintained by the Contractor to either LDH or its designee.
- Describe the Contractor's approach for the transfer of all records, data, and operational support information, as applicable, to either LDH or its designee.
- 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.
- Include copies of all relevant Enrollee and PBM Covered Services data, documentation, and other pertinent information necessary, as determined by LDH, for LDH or a subsequent contractor to assume the operational activities successfully. This includes, but is not limited to, correspondence, documentation of ongoing outstanding issues, and other operations support documentation.

2.1.30.2 Transfer of Data

The Contractor shall transfer all data regarding the provision of PBM Covered Services to LDH or its designee, at the sole discretion of LDH and as directed by LDH. All transferred data must be transferred in compliance with HIPAA.

All required transfers of data and information specified in the Contract shall be made electronically, unless otherwise directed by LDH, and according to the format and schedule approved by LDH.

All data received shall be verified by LDH or the subsequent contractor. If LDH determines that not all of the data regarding the provision of PBM Covered Services was transferred to LDH or the subsequent contractor, 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.

2.1.30.3 Post-Turnover Services

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.

If the Contractor does not provide the required data and reference tables, documentation, and/or other pertinent information necessary for LDH or the subsequent contractor 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.
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.

The Contractor shall maintain all data and records related to Enrollees and Providers for ten (10) years after the date of final payment under the Contract or until the resolution of all litigation, Drug Claims, financial management review or audit pertaining to the Contract, whichever is longer. Under no circumstances shall the Contractor or any 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.

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.

2.1.31 Reports and Requests for Information

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

- All information required under the Contract, or other information related to the performance of Contract responsibilities as requested by LDH or an MCO.
- All reports and associated requirements as specified in the Contract and the **MCO Manual.**
- 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.
- Delivery of time sensitive data to LDH or an MCO.
- High quality, accurate data in the format and in the manner of delivery specified by LDH.

The Contractor shall respond to requests for information from LDH or an MCO within the following timelines:

- Requests from LDH or an MCO 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 or the MCO in the request.
- Requests that originate from the Office of the Governor, the LDH Office of the Secretary, or a Louisiana legislator shall be addressed within seventy-two (72) hours.
- Requests from the LDH Provider Relations Unit shall be addressed within five (5) Business Days.
- 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.

If the Contractor does not provide the requested information within the timeframes outlined in the Contract or in the request, the MCO(s) may assess Monetary Penalties as outlined in Attachment G, *Table of Monetary Penalties*.

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

- 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.
- 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.
- 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.

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

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

2.2 Deliverables

Project deliverables, required and/or expected outcomes, and any required timetables are in Attachment VI.

2.3 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 the Contract to provide written notice to the Contractor, such notice shall be signed by the Medicaid Executive Director or his/her designee.

3 EVALUATION

3.1 Evaluation Criteria and Assigned Points

Proposals that pass the preliminary screening and mandatory requirements review will be evaluated based on information provided in the proposal. The evaluation will be conducted according to the following:

Evaluation Criteria	Maximum Score
Executive Summary	**25**
Company Background and Experience	**75**
Approach and Methodology	**795**
• Administrative Data	20
• Work Plan/Project Execution	80
• Detailed Scope Response	695
○ Coordination with MCOs	*75*
○ Pharmacy and Prescriber Network	*50*
○ Drug Claims/System Requirements	*100*
○ Covered Drug List/Preferred Drug List (Single PDL)	*75*
○ Behavioral Health Policies and Procedures	*15*
○ Specialty Drugs and Pharmacies	*10*
○ Drug Utilization Review	*50*
○ Provider and Enrollee Support	*50*
○ Oversight and Monitoring	*25*
○ State and Federal Mandate Compliance	*25*
○ Audit	*25*
○ Security and Privacy	*75*
○ Reporting and Quality Assurance	*25*
○ Emergency and Disaster Planning	*25*
○ Continuity of Operations Plan (COOP)	*25*
○ Other Requirements	*25*
○ Innovative Concepts and Value Added Services	*20*
Proposed Staff Qualifications	**50**
Louisiana Veteran and/or Hudson Initiative • *Up to 10 % available for Hudson-certified proposers;* • *Up to 12 % available for Veteran-certified proposers;* • *If no Veteran-certified proposers, those two points are not awarded.* *See Section V.A.4 for details*	**180**
Cost	**375**
• Transaction Fee ($ / paid Drug Claim)	225
• Professional Dispensing Fee ($ / paid Drug Claim)	75
○ Non-Local Pharmacy Professional Dispensing Fee for brand drugs	*25*

○ Non-Local Pharmacy Professional Dispensing Fee for generic drugs	*25*
○ Non-Local Pharmacy Professional Dispensing Fee for Specialty Drugs	*25*
• Ingredient Cost Methodology	75
○ Non-Local Pharmacy ingredient cost discount for brand drugs	*25*
○ Non-Local Pharmacy ingredient cost discount for generic drugs	*25*
○ Non-Local Pharmacy ingredient cost discount for Specialty Drugs	*25*
TOTAL SCORE	**1500**

Proposer must receive a minimum score of 472.5 points (50%) of the total available points in the technical categories of Executive Summary, Company Background and Experience, Approach and Methodology, and Proposed Staff Qualifications to be considered responsive to the RFP. Proposals not meeting the minimum score shall be rejected and not proceed to further Cost or Louisiana Veteran and/or Hudson Initiative evaluation.

The scores for the Cost Proposals, Technical Proposals and Veteran and Hudson Initiative will be combined to determine the overall score. The Proposer with the highest overall score will be recommended for award.

3.2 Cost Evaluation

a. The assignment of the cost score based on the below formulas will be calculated by a member of the LDH staff.
b. For the Transaction Fee, the Proposer with the lowest average Transaction Fee across all three (3) years, equally weighted, shall receive the full points of that section's total. Other Proposers shall receive points for cost based upon the following formula:

Transaction Fee

CCS = (LTF/TF)* Total Points

CCS = Computed Cost Score (points) for Proposer being evaluated.

LTF = Lowest Transaction Fee of all Proposers, calculated as the average Transaction Fee across all three (3) years, equally weighted.

TF = Transaction Fee for the Proposer being evaluated, calculated as the average Transaction Fee across all three (3) years, equally weighted.

c. For the Professional Dispensing Fee, the Non-Local Pharmacy Professional Dispensing Fee for brand drugs, generic drugs, and Specialty Drugs shall be considered separately. For each subcategory (brand, generic, and Specialty), the Proposer with the lowest average Non-Local Pharmacy Professional Dispensing Fee across all three (3) years, equally weighted, shall receive the full points for that subcategory. Other Proposers shall receive points for cost based upon the following formula:

Professional Dispensing Fee

CCS = (LPDF/PDF)* Total Points

CCS = Computed Cost Score (points) for Proposer being evaluated, calculated separately for brand drugs, generic drugs, and Specialty Drugs.

LPDF = Lowest Professional Dispensing Fee of all Proposers, calculated as the average Non-Local Pharmacy Professional Dispensing Fee across all three (3) years, equally weighted, and calculated separately for brand drugs, generic drugs, and Specialty Drugs.

PDF = Professional Dispensing Fee for the Proposer being evaluated, calculated as the average Non-Local Pharmacy Professional Dispensing Fee across all three (3) years, equally weighted, and calculated separately for brand drugs, generic drugs, and Specialty Drugs.

d. For the Ingredient Cost Methodology, the Non-Local Pharmacy ingredient cost discount for brand drugs, generic drugs, and Specialty Drugs shall be considered separately. For each subcategory (brand, generic, and Specialty), the Proposer with the highest average Non-Local Pharmacy ingredient cost discount across all three (3) years, equally weighted, shall receive the full points for that subcategory. Other Proposers shall receive points for cost based upon the following formula:

Ingredient Cost Methodology

CCS = (ICD/HICD)* Total Points

CCS = Computed Cost Score (points) for Proposer being evaluated, calculated separately for brand drugs, generic drugs, and Specialty Drugs.

HICD = Highest Ingredient Cost Discount of all Proposers, calculated as the average Non-Local Pharmacy ingredient cost discount across all three (3) years, equally weighted, and calculated separately for brand drugs, generic drugs, and Specialty Drugs.

ICD = Ingredient Cost Discount for the Proposer being evaluated, calculated as the average Non-Local Pharmacy ingredient cost discount across all three (3) years, equally weighted, and calculated separately for brand drugs, generic drugs, and Specialty Drugs.

3.3 Veteran-Owned and Service-Connected Disabled Veteran-Owned Small Entrepreneurships (Veteran Initiative) and Louisiana Initiative for Small Entrepreneurships (Hudson Initiative) participation

a. Twelve percent (12%) of the total evaluation points in this RFP are reserved for Proposers who are certified small entrepreneurships, or who will engage the participation of one or more certified small entrepreneurships as Subcontractors. Reserved points shall be added to the applicable Proposers' evaluation score as follows:

b. Proposer Status and Allotment of Reserved Points

i. If the Proposer is a certified Veterans Initiative small entrepreneurship, the Proposer shall receive points equal to twelve percent (12%) of the total evaluation points in this RFP.
ii. If the Proposer is a certified Hudson Initiative small entrepreneurship, the Proposer shall receive points equal to ten percent (10%) of the total evaluation points in this RFP.
iii. If the Proposer demonstrates its intent to use certified small entrepreneurship(s) in the performance of contract work resulting from this solicitation, the Proposer shall receive points equal to the net percentage of contract work which is projected to be performed by or through certified small entrepreneurship Subcontractors, multiplied by the appropriate number of evaluation points. For purposes of this Hudson/Veterans calculation only, the estimated value of the contract to be awarded is seven (7) billion dollars.
iv. The total number of points awarded pursuant to this Section shall not exceed twelve percent (12%) of the total number of evaluation points in this RFP.

c. If the Proposer is a certified Veterans Initiative or Hudson Initiative small entrepreneurship, the Proposer must note this in its proposal in order to receive the full amount of applicable reserved points.

d. If the Proposer is not a certified small entrepreneurship, but has engaged one (1) or more Veterans Initiative or Hudson Initiative certified small entrepreneurship(s) to participate as Subcontractors, the Proposer shall provide the following information for each certified small entrepreneurship Subcontractor in order to obtain any applicable Veterans Initiative or Hudson Initiative points:

i. Subcontractor's name.
ii. Subcontractor's Veterans Initiative and/or the Hudson Initiative certification.
iii. A detailed description of the work to be performed.
iv. The anticipated dollar value of the subcontract for the three-year contract term.

Note – *It is not mandatory to have a Veterans Initiative or Hudson Initiative certified small entrepreneurship Subcontractor. However, it is mandatory to include this information in order to receive any allotted points when applicable.*

e. If multiple Veterans Initiative or Hudson Initiative Subcontractors will be used, the above required information should be listed for each Subcontractor. The Proposer should provide a sufficiently detailed description of each Subcontractor's work so the Department is able to determine if there is duplication or overlap, or if the Subcontractor's services constitute a distinct scope of work from each other Subcontractor(s).

4 PERFORMANCE STANDARDS

4.1 Performance Requirements

Failure to comply with the requirements and performance standards set forth in this RFP may result in the assessment of a Monetary Penalty per incident and/or per Calendar Day of non-compliance. The Contractor shall be held responsible for performance standards and measures directly related to the provision of services as set forth herein and in the MCO manual available in the Procurement Library. Repeated incidents of non-compliance may result in termination of the contract. 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 the MCOs.

Attachment V, Table of Monetary Penalties specifies permissible Monetary Penalties for certain violations of the Contract. For any violation not explicitly described in the table, the MCO may impose a Monetary Penalty of up to five thousand dollars ($5,000) per occurrence and/or per Calendar Day to the Contractor.

The Department will monitor and measure the performance of the Contractor by:

- Assuring that all State and Federal requirements are promptly and appropriately implemented.
- Assuring that the recovered funds balance with the invoice and authorizing the disposition of th e associated funds that correspond to the appropriate expenditures.
- Reviewing and ensuring the accuracy of invoices and authorizing invoice payment.
- Providing access to any and all systems or files which the Department determines necessary for the fulfillment of contractual requirements.
- Participating with the Contract in developing a report delivery schedule listing the time and location of delivery of reports produced by the Contractor. Such schedule will be used to determ ine whether or not penalties for late reports are to be assessed.
- Providing review for approval or rejection of any replacement of Contractor staff within thirty (30) Calendar Days of notification to the Department of such proposed change. The Department may request any Contractor personnel changes at any time that it deems necessary with regard to the contract.

4.2 Return of Funds

All amounts owed by the Contractor to a MCO, as identified through routine or investigative reviews of records or audits conducted by the MCO, LDH, or other State or Federal agency, as well as Monetary Penalties levied against the Contractor for Contract non-compliance, may be deducted from future payments upon notification by the MCO.

Amounts that exceed or cannot otherwise be collected through payment deduction shall be due and payable to the MCO no later than thirty (30) Calendar Days following notification to the Contractor by the MCO, unless otherwise authorized in writing by the MCO. The MCO 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.

4.3 Other Payment Terms

The Contractor shall make payments to Network Providers as specified in the Contract.

Payment for items or services provided under the Contract will not be made to any entity located outside of the United States.

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.

Should any part of the scope of work under the 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 the 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.

4.4 Performance Measurement/Evaluation/Monitoring Plan

Contracts between the Contractor and the MCOs must contain provisions authorizing MCOs to review performance standards and if desired, penalize the Contractor with monetary penalties based on their performance.

4.5 Veteran and Hudson Initiative Programs Reporting Requirements

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.

If a contract is awarded to a Proposer who proposed a good faith subcontracting plan, LDH, the Louisiana Department of Economic Development (LED), or OSP may audit Contractor to determine whether Contractor has complied in good faith with its subcontracting plan. The Contractor must be able to provide supporting documentation (i.e., phone logs, fax transmittals, letter, e-mails) to demonstrate its good faith subcontracting plan was followed. If it is determined at any time by LDH, LED, or the OSP Director that the Contractor did not in fact perform in good faith its subcontracting plan, the contract award or the existing contract may be terminated.

CERTIFICATION STATEMENT

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Request for Proposals (RFP), including attachments.

OFFICIAL CONTACT: The State requests that the Proposer designate one person to receive all documents and the method in which the documents are best delivered. Identify the Contact name and fill in the information below: (Print Clearly)

Date	
Official Contact Name	
Email Address	
Fax Number with Area Code	
Telephone Number	
Street Address	
City, State, and Zip	

Proposer certifies that the above information is true and grants permission to the Department to contact the above named person or otherwise verify the information I have provided.

By its submission of this proposal and authorized signature below, Proposer certifies that:

1. The information contained in its response to this RFP is accurate.
2. Proposer complies with each of the mandatory requirements listed in the RFP and will meet or exceed the functional and technical requirements specified therein.
3. Proposer accepts the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
4. Proposer's technical and cost proposals are valid for ninety (90) Calendar Days from the date of Proposer's signature below.
5. Proposer understands that if selected as the successful Proposer, he/she will have thirty (30) Calendar Days from the date of delivery of initial contract in which to complete contract negotiations, if any, and fourteen (14) Calendar Days to execute the final contract document. The Department has the option to waive this deadline if actions or inactions by the Department cause the delay.
6. Proposer certifies, by signing and submitting a proposal for twenty-five thousand dollars ($25,000) or more, that their company, any Subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in 45 CFR Part 75, Subpart

F. (A list of parties who have been suspended or debarred can be viewed via the internet at https://www.sam.gov).

7. Proposer understands that, if selected as a contractor, the Louisiana Department of Revenue must determine that it is current in the filing of all applicable tax returns and reports and in payment of all taxes, interest, penalties, and fees owed to the State and collected by the LDR. Proposer shall comply with La. R.S. 39:1624(A)(10) by providing its seven-digit LDR account number in order for tax payment compliance status to be verified.
8. Proposer further acknowledges its understanding that issuance of a tax clearance certificate by LDR is a necessary precondition to the approval of any contract by the Office of State Procurement. The contracting agency reserves the right to withdraw its consent to any contract without penalty and proceed with alternate arrangements, should a prospective contractor fail to resolve any identified outstanding tax compliance discrepancies with the LDR within seven (7) Calendar Days of such notification.
9. In preparing its response, the Proposer has considered all proposals submitted from qualified, potential Subcontractors and suppliers, and has not, in the solicitation, selection, or commercial treatment of any Subcontractor or supplier, refused to transact or terminate business activities, or take any other action intended to limit commercial relations, with a person or entity that is engaging in commercial transactions in Israel or Israeli-controlled territories, with the specific intent to accomplish a boycott or divestment of Israel. Proposer also has not retaliated against any person or other entity for reporting such refusal, termination, or commercially limiting action. The State reserves the right to reject the response of the Proposer if this certification is subsequently determined to be false, and to terminate any contract awarded based on such a false response.
10. Proposer certifies that the cost submitted was independently arrived at without collusion.

Authorized Signature: _____

_____

Print Name: _____

Title: _____

Attachment II: CF-1 form placeholder

COST TEMPLATE

Proposers must complete a cost proposal in the following format to be considered for award. Failure to complete will result in the disqualification of the proposal.

Guaranteed Pricing Terms

Instructions: The Transaction Fee, paid by the MCO to the Contractor, shall be proposed as a dollar amount per paid Drug Claim as payment-in-full for all services performed by the Contractor. If the dollar amount per paid Drug Claim is not the same every year, an average will be calculated for comparison and evaluation purposes.

Transaction Fee ($ / paid Drug Claim)	Contract Year 1	Contract Year 2	Contract Year 3
Transaction Fee			

Instructions: The Non-Local Pharmacy Professional Dispensing Fee shall be proposed as a dollar amount per paid Drug Claim. If the dollar amount per paid Drug Claim is not the same every year, an average will be calculated for comparison and evaluation purposes.

Note: In accordance with La. R.S. 46:460.36, the Contractor shall not pay a Local Pharmacy a per-prescription reimbursement at a rate less than the published FFS reimbursement rate for the combination of the ingredient cost and Professional Dispensing Fee in effect on the DOS or the U&C Charge, whichever is lower.

Professional Dispensing Fee ($ / paid Drug Claim)	Contract Year 1	Contract Year 2	Contract Year 3
Non-Local Pharmacy Professional Dispensing Fee for brand drugs			
Non-Local Pharmacy Professional Dispensing Fee for generic drugs			
Non-Local Pharmacy Professional Dispensing Fee for Specialty Drugs			

Instructions: Non-Local Pharmacy ingredient cost discount shall be reported as a percentage of Average Wholesale Price (AWP). If the percentage of AWP is not the same every year, an average will be calculated for comparison and evaluation purposes. The Proposer shall provide a transparent pass-through model of reimbursement.

Ingredient Cost Methodology	Contract Year 1	Contract Year 2	Contract Year 3
Non-Local Pharmacy ingredient cost discount for brand drugs			
Non-Local Pharmacy ingredient cost discount for generic drugs			
Non-Local Pharmacy ingredient cost discount for Specialty Drugs			

Attachment IV: Proposal Label

COMPLETE AND ATTACH LABEL TO PACKAGE CONTAINING PROPOSAL

RFP NAME: _____

RFP Number: _____

OPEN BID DATE AND TIME: _____

LABEL: Competitive Sealed Proposal

Attachment V: Table of Monetary Penalties

Table of Monetary Penalties

The MCOs may impose the following monetary penalties against the Contractor.

Failed Deliverable or Deficiency	Penalty
Contract Transition and Readiness	
Operational Start Date	Fifty thousand dollars ($50,000) per Calendar Day for each Calendar Day beyond the Operational Start Date that the Contractor has not fully satisfied the Readiness Requirements, as determined by LDH.
Readiness Review	Five thousand dollars ($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 Calendar 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.
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.
Services	
Covered Outpatient Drugs	The actual cost incurred by an Enrollee for obtaining Covered Outpatient Drugs 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 Covered Outpatient Drugs 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.
Preferred Drug List (PDL)	One hundred thousand dollars ($100,000) per quarter in which the overall PDL compliance rate is less than ninety-two percent (92%). One hundred thousand dollars ($100,000) per quarter in which the brand-over-generic PDL compliance rate is less than ninety-two percent (92%).
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.
Provider Network, Support, and Reimbursement	
Provider Network and Reimbursement	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 Relations	Fifteen thousand dollars ($15,000) per Calendar Day for failure to provide staff to handle 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 provide appropriate clinical personnel from 7 a.m. to 7 p.m. Central Time, Monday through Friday.
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 a monthly 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.
Enrollee Services, Marketing, Grievances	
Enrollee Help Desk	Five thousand dollars ($5,000) per Calendar Day for failure to provide appropriate staff to answer calls from Enrollees from 7:00 a.m. to 7:00 p.m. Central Time, Monday through Friday. Five thousand dollars ($5,000) per Calendar Day for failure to provide a voice message system to receive calls outside of 7:00 a.m. to 7:00 p.m. Central Time, Monday through Friday. 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 a monthly reporting period.
Marketing/Steerage	Ten thousand dollars ($10,000) per marketing and education violation/incident outlined in the Contract. Five thousand dollars ($5,000) per Beneficiary that the Contractor or its Subcontractors steered.
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 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.
Drug Claims Management	
Prompt Pay	Five thousand dollars ($5,000) for the first month that the Drug Claims performance percentages that Drug Claims fall below the performance standard. Twenty-five thousand dollars ($25,000) for each additional month that the Drug Claims performance percentages fall below the performance standards.
Drug Claims Processing	One thousand dollars ($1,000) per Drug 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 Drug Claim upon identification of DUR initiatives not or incorrectly implemented, plus five thousand dollars ($5,000) per Calendar Day until programming is corrected and implemented.
Inappropriate Payment Denials, Delays, or Recoupments	The value of Drug Claims inappropriately denied, delayed, or recouped multiplied by a factor of 1.5.
Drug Claims Summary Report	One thousand dollars ($1,000) per Calendar Day that the Drug Claims summary report is late, inaccurate, or incomplete.
Drug Claims Data	Ten thousand dollars ($10,000) per Calendar Day for failure to timely submit the Drug Claims file to the MCO. Ten thousand dollars ($10,000) per Calendar Day for failure to submit accurate and complete Drug Claims data to the MCO. 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.
Systems and Technical Requirements	
Information Systems Availability	Fifteen thousand dollars ($15,000) per Calendar Day per core eligibility/enrollment and Drug 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.
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 Drug 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) Calendar 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 the Contract.

For any violation not explicitly described in the table above, the MCO may impose a monetary penalty of up to $5,000 per occurrence per Calendar Day.

Attachment VI: Table of Deliverables

Table of Deliverables

Deliverable ID#	Deliverable Name	Frequency	Due Date	Description
PBM-1	Risk Assessment Report	Annually based on the SFY	August 1st of each year.	Perform a risk assessment of the Drug Claims processing system and Drug Claim operations business processes on an annual basis and provide a written report including the methodology to conduct the assessment, findings, and planned action(s) to mitigate identified risk(s) and address identified issues.
PBM-2	System Up-Time Report	Monthly	Fifteen (15) Calendar Days after the end of each calendar month.	Conduct online POS operations twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year no less than ninety-nine and nine-tenths percent (99.9%) of the time, except for scheduled downtime pre-approved by LDH. • Notify the MCOs and LDH in advance regarding scheduled downtime occurrences. • Measure and report system up-time monthly. • Notify LDH and MCO staff of performance issues impacting POS Adjudication within thirty (30) minutes of the Contractor's knowledge of system problems.
PBM-3	Claims Processing Edit List	Quarterly	Thirty (30) Calendar Days after the end of each calendar quarter (April 30th, July 30th, October 30th, and January 30th).	Develop and maintain a current list of all edits and identify those edits that require PA and provide to LDH quarterly.

Deliverable ID#	Deliverable Name	Frequency	Due Date	Description
PBM-4	PDL Compliance Quality Monitoring Report	Monthly	Fifteen (15) Calendar Days after the end of each calendar month.	Achieve at least a ninety-two percent (92%) overall compliance rate and at least a ninety-two percent (92%) compliance rate for each medication on the brand-over-generic list provided by LDH (calculated as brand/ (brand + generic). Failure to meet both standards may result in monetary penalties. • Measure the accuracy of its implementation and maintenance of the Louisiana Medicaid PDL and report findings to LDH monthly. Monthly reports shall include an attestation from the Contractor's Executive Director as to the accuracy of the measurement.
PBM-5	Monthly PA Reports Operational Clinical Financial	Monthly	Fifteen (15) Calendar Days after the end of each calendar month.	Provide detailed monthly operational, clinical, and financial reporting on all prior authorization activities. Reports shall be available by drug, drug class, Enrollee, Provider, and other defined parameters. PA reports shall include, but not be limited to: • Number of PAs • Denial/ approval rates • Number of automated vs. manual PAs • Drug • Overall health care savings • Return on investment
PBM-6	Emergency Fill Report	Monthly	Fifteen (15) Calendar Days after the end of each calendar month.	Reimburse the pharmacy for both the ingredient and the Professional Dispensing Fee for both emergency supply fills. Emergency fills may be included in a post payment review and shall be reported monthly to LDH to identify misuse.
PBM-7	CMS DUR Annual Report	Annually	To be negotiated between the MCOs and the Contractor.	Provide reports and data annually to each MCO, as requested, for the CMS DUR annual report.

Deliverable ID#	Deliverable Name	Frequency	Due Date	Description
PBM-8	Customer Service Center Quality Audit Report	Quarterly	Thirty (30) Calendar Days after the end of each calendar quarter (April 30th, July 30th, October 30th, and January 30th).	Perform a quarterly self-audit of CSC inquiries to ensure inquiries were addressed appropriately, accurately, courteously, and timely, and in accordance with State policies and procedures. • Provide LDH and the MCOs with quarterly reports of the customer service center audit, including findings and any remediation activities.
PBM-9	Customer Service Center Quality Assurance (QA) Management Plan	Readiness Review, Annually, prior to implementing changes, and upon request from LDH	Thirty (30) Calendar Days after the Contract Start Date; August 1st of each year thereafter; at least thirty (30) Calendar Days prior to implementing any changes; and within two (2) Business Days of a request from LDH.	A Quality Assurance (QA) program that includes call sampling and follow up to confirm efficient handling and measure caller satisfaction.

Deliverable ID#	Deliverable Name	Frequency	Due Date	Description
PBM-10	PBM Quality Management Monitoring and Audit Plan	Readiness Review, Annually based on the SFY, prior to implementing changes, and upon request from LDH	Thirty (30) Calendar Days after the Contract Start Date; August 1st of each year thereafter; at least thirty (30) Calendar Days prior to implementing any changes; and within two (2) Business Days of a request from LDH.	The Contractor shall submit a written description of the assurances and procedures that shall be put in place, such as an independent audit, to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information. These assurances and procedures shall be transmitted to LDH for review and approval prior to the date pharmacy services begin.
PBM-11	Project Management Report: Claim Review Activities	Annually based on the SFY	August 1st of each year.	Develop a Project Management Report detailing a brief review of the year's Drug Claim review activities broken out by Drug Claim review type. The report shall summarize, at a minimum: • Any policy and procedure changes the Contractor has implemented or suggested to LDH. • Number of Drug Claim reviews performed, potential recoupment, actual recoupment amounts, and number of open reconsiderations.
PBM-12	Annual SOC 2 Type II System Independent Audit	Annually	Six (6) months after the end of the Contractor's fiscal year.	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.

Deliverable ID#	Deliverable Name	Frequency	Due Date	Description
PBM-13	QA Plan	Readiness Review, Annually, prior to implementing changes, and upon request from LDH	Thirty (30) Calendar Days after the Contract Start Date; August 1st of each year thereafter; at least thirty (30) Calendar Days prior to implementing any changes; and within two (2) Business Days of a request from LDH.	Develop, deliver, and execute a QA Plan, subject to LDH's approval. • Minimally, this plan shall include quality oversight, monitoring, and monthly reporting on the Contractor's activities. • These reports shall clearly demonstrate the Contractor's compliance with contract requirements and performance guarantees with attention to continuous quality improvement.
PBM-14	Performance Status Report	Monthly	Fifteen (15) Calendar Days after the end of each calendar month.	Provide a monthly performance status report that includes: • Activities and operational statistics. • Issues and recommendations regarding current policies, procedures, and focus areas. • Top one hundred (100) prescriptions paid by dollar amount, therapeutic class, and by drug entity (name, form, and strength).

Deliverable ID#	Deliverable Name	Frequency	Due Date	Description
PBM-15	Pharmacy claim processing and procedure manual	Readiness Review, Quarterly, prior to implementing changes, and upon request from LDH.	Thirty (30) Calendar Days after the Contract Start Date; thirty (30) Calendar Days after the end of each calendar quarter (April 30th, July 30th, October 30th, and January 30th); at least thirty (30) Calendar Days prior to implementing any changes; and within two (2) Business Days of a request from LDH.	Develop and maintain, on a quarterly basis, an LDH-approved non-proprietary Drug Claim processing and procedure manual to be published on the Louisiana Medicaid Program website, MCO website and on the Contractor's website as a Provider reference. This manual shall explain how to bill Drug Claims for proper reimbursement.
PBM-16	Pharmacy Provider Claims Review Report	Quarterly	Thirty (30) Calendar Days after the end of each calendar quarter (April 30th, July 30th, October 30th, and January 30th).	Provide LDH, on a quarterly basis and in a format as required by LDH, a report detailing the results of contacts of Network Providers where Drug Claims data appeared questionable.
PBM-17	Claim Overpayment Report	Quarterly	Thirty (30) Calendar Days after the end of each calendar quarter (April 30th, July 30th, October 30th, and January 30th).	Conduct and report a quarterly systematic review of all paid Drug Claims to identify and determine overpayments.

Deliverable ID#	Deliverable Name	Frequency	Due Date	Description
PBM-18	Executive Dashboard Report – Pharmacy Claims Processed	Monthly	Fifteen (15) Calendar Days after the end of each calendar month.	Produce a monthly executive level dashboard summary report for Drug Claims processed.
PBM-19	Specialty Drugs Claims Report	Monthly	Fifteen (15) Calendar Days after the end of each calendar month.	Produce a monthly report for all Drug Claims paid for Specialty Drugs. This report shall include a breakdown of drugs dispensed and shall be broken down by LDH-identified criteria.
PBM-20	340B Claims Report	Monthly	Fifteen (15) Calendar Days after the end of each calendar month.	Produce a monthly report for all Drug Claims processed under the 340B program to ensure compliance with the LDH 340B policy.
PBM-21	TPL/ Other Insurance Claims Report	Monthly	Fifteen (15) Calendar Days after the end of each calendar month.	Provide a monthly report summarizing all Drug Claims where TPL/dual eligible Drug Claims, identified at the point of sale, either through TPL codes submitted on the Drug Claim or via eligibility file or real-time TPL identification software.
PBM-22	Morphine Milligram Equivalents Claims Report	Monthly	Fifteen (15) Calendar Days after the end of each calendar month.	Produce a monthly report detailing morphine milligram equivalents (MME) which reports any Enrollees who are potential outliers and exceed the MME recommendations.
PBM-23	Pro-DUR Claims Report	Monthly	Fifteen (15) Calendar Days after the end of each calendar month.	Produce a monthly ProDUR summary report with LDH-approved content (e.g., Prospective Payment System (PPS), Prior Authorization/Medical Certification Code (PAMC) and Submission Clarification Code (SCC) codes such as: the reason for service code broken down by severity, count, and amount paid).
PBM-24	ProDUR Paid Savings Report	Monthly	Fifteen (15) Calendar Days after the end of each calendar month.	Produce a monthly ProDUR paid savings report with LDH-approved content (e.g., Drug Claim detail for ProDUR related reversals and associated savings).

Deliverable ID#	Deliverable Name	Frequency	Due Date	Description
PBM-25	PDL Quarterly Operations Report	Quarterly	Thirty (30) Calendar Days after the end of each calendar quarter (April 30th, July 30th, October 30th, and January 30th).	Create a PDL Quarterly Operations Report that shall include at a minimum: • prior authorization approval and denial statistics related to PDL classes and non-PDL drugs, • most common reasons for denial of each class, • statistics related to PDL compliance in each class, utilization and costs statistics related to the drugs in each PDL class, and • any other information requested by LDH.
PBM-26	PBM Claim Trends Report	Quarterly	Thirty (30) Calendar Days after the end of each calendar quarter (April 30th, July 30th, October 30th, and January 30th).	Provide reports that clearly show trends over time, highlighting any identified problem areas in terms of both cost and volume.
PBM-27	PBM Drug Rate Payment Report	Quarterly	Thirty (30) Calendar Days after the end of each calendar quarter (April 30th, July 30th, October 30th, and January 30th).	Provide reports that include the rates paid for drugs to the pharmacies and confirmation that the Contractor did not receive any rebates or other discounts related to drugs.

Deliverable ID#	Deliverable Name	Frequency	Due Date	Description
PBM-28	Continuity of Operations (COOP) Plan	Readiness Review, Annually, prior to implementing changes, and upon request from LDH	Thirty (30) Calendar Days after the Contract Start Date; August 1st of each year thereafter; at least thirty (30) Calendar Days prior to implementing any changes; and within two (2) Business Days of a request from LDH.	The Contractor shall submit the Continuity of Operations Plan to LDH or its designee for approval.
PBM-29	Turnover Plan	At the beginning and end of the Contract term, prior to implementing changes, and upon request from LDH	One hundred eighty (180) Calendar Days after the Contract Start Date; at least six (6) months prior to the end of the Contract term; at least thirty (30) Calendar Days prior to implementing any changes; and within two (2) Business Days of a request from LDH.	• The Turnover Plan shall be comprehensive detailing the proposed schedule, activities, and resource requirements associated with turnover tasks. • The Contractor shall turnover all completed Contract deliverable work including all working documents, in accordance with the LDH approved Turnover Plan. Activities include, but are not limited to: o maintenance of system files. o software, and hardware. o correction of system problems and deficiencies. o system modifications as necessary to accommodate LDH's needs without additional cost to LDH.
PBM-30	MCO monthly and quarterly reports	Monthly or Quarterly	To be determined by the MCOs.	Provide data for all LDH monthly and quarterly reporting requirements.