



Dental Benefit Program Request for Proposals

RFP# 305PUR-DHHRFP-DBP-MVA

Release Date: December 18, 2012

**Proposal Due Date/Time: January 17, 2013
4:00 P.M. CT**

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1. General Information

1.1. Background

Mission of the Louisiana Department of Health and Hospitals (DHH) is to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the state of Louisiana. DHH is dedicated to fulfilling its mission through direct provision of quality services, the development and stimulation of services of others, and the utilization of available resources in the most effective cost manner.

1.1.1.

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

1.1.2.

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

1.1.3.

Medicaid consists of the following four major Divisions and one section: 1) Medicaid Managed Care Program known as Bayou Health; 2) Eligibility Field Operations, Systems, Policy and Supports; 3) Waiver Assistance and Compliance, and Policy and Planning; 4) Financial Management, Recovery and Premium Assistance, and Supplemental Payments; and Medicaid Management Information System Section (MMIS).

1.2. Purpose of RFP

1.2.1.

The purpose of this Request for Proposals (RFP) is to solicit proposals from qualified entities to provide dental healthcare services to enrollees of traditional fee-for-service (FFS) Medicaid, enrollees of Bayou Health Shared Savings Plans or Bayou Health Prepaid Health Plans, utilizing the most cost effective manner and in accordance with the terms and conditions set forth herein.

1.2.2.

Through this RFP, DHH will solicit proposals for a coordinated care network for dental services from entities to serve as a statewide Dental Benefit Program Manager (DBPM), herein referred to as Health Plan, for those recipients who remain in FFS Medicaid and/or enrollees of Bayou Health Shared Savings Plans or Bayou Health Prepaid Health Plans.

1.2.3.

DHH anticipates that the implementation of the Louisiana Medicaid Dental Benefit Program (DBP) will achieve the following:

- Improved coordination of care;
- Better dental health outcomes;
- Increased quality of dental care as measured by metrics such as HEDIS and those being developed by the Dental Quality Alliance;
- Improved access to essential specialty dental services;
- Outreach and education to promote healthy behaviors;
- Increased personal responsibility and self-management;
- A reduction in the rate of avoidable hospital stays and readmissions;
- A decrease in fraud, abuse, and wasteful spending;
- Greater accountability for the dollars spent;
- A more financially sustainable system; and

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- Net savings to the state compared to the existing FFS Medicaid delivery system.

1.2.4.

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

1.2.5.

Through this RFP, DHH seeks to contract for the needed services and to give ALL qualified businesses, including those that are owned by minorities, women, veterans (see Attachment A), persons with disabilities, and small business enterprises, opportunity to do business with the state as the DBPM.

1.2.6.

This RFP process is being used so that DHH may selectively contract with a Health Plan necessary to serve the eligible Medicaid recipients. The number of awards is at the sole discretion of the Secretary.

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

1.2.7.

State authority for DHH to implement the DBP is contained in L.R.S. 36:254 which provides the Secretary of DHH with the authority to implement managed care requirements of HB 1 of the 2010 Regular Session of the Louisiana Legislature.

1.2.8.

Federal Authority for DHH to implement the DBP is contained in Section 1932(a) (1)(A) of the Social Security Act as Amended and 42 CFR, Part 438; as those requirements apply to PAHPs. DHH intends to submit a State Plan Amendment to implement the DBP.

1.3. Invitation to Propose

DHH is inviting qualified proposers to submit proposals to provide specified healthcare services statewide for Medicaid recipients enrolled in the DBP in return for a monthly capitation payment made in accordance with the specifications and conditions set forth herein. The service area is the entire state.

1.4. RFP Coordinator

1.4.1.

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

Gail Williams
Section Chief
Louisiana Department of Health and Hospitals
628 North 4th Street, Baton Rouge, LA 70802
Telephone Number: (225) 342-7878
Facsimile Number: (225) 342-9243
Email: Gail.B.Williams@la.gov

1.4.2.

This RFP is available at the following web links: <http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47> and <http://www.prd1.doa.louisiana.gov/OSP/LaPAC/pubMain.cfm> and <http://www.makingmedicaidbetter.com>

1.5. Communications

All communications relating to this RFP must be directed to the DHH RFP Coordinator named above. All communications between Proposers and other DHH staff members concerning this RFP shall be strictly prohibited. Failure to comply with these requirements shall result in proposal disqualification.

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1.6. Proposer Comments

1.6.1.

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

1.6.2.

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

- has waived any claim of error or ambiguity in the RFP or resulting Contract;
- cannot contest DHH’s interpretation of such provision(s); and
- will not be entitled to additional compensation, relief or time by reason of the ambiguity, error, or its later correction.

1.6.3.

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

1.6.4.

The Proposer shall provide an electronic copy of the comments/questions in Microsoft Excel table with these columns in this order: Submitter Name, Document Reference (e.g., RFP, RFP Companion Guide), Section Number, Section Heading, Page Number in Referenced Document, and Question.

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

<http://wwwpr1.doa.louisiana.gov/OSP/LaPAC/pubMain.cfm> , and
<http://www.makingmedicaidbetter.com> and may also be posted at:
<http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47>.

1.6.5.

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

1.6.6.

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

1.7. Notice of Intent to Propose

1.7.1.

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

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

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1.7.2.

A Notice of Intent to Propose creates no obligation and is not a prerequisite for making a proposal. However, those submitting a Notice of Intent to Propose are required to subscribe to LaPAC to receive notification of Internet postings of RFP addendums and other communications regarding the RFP.

1.7.3.

Copies of Notices of Intent to Propose received by DHH will be posted upon receipt on the following websites:

<http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/pubMain.cfm> , and
<http://www.makingmedicaidbetter.com> and may also be posted at
<http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47>

1.8. Pre-Proposal Conference

1.8.1.

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

1.8.2.

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

<http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/pubMain.cfm> , and
<http://www.makingmedicaidbetter.com> and may also be posted at
<http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47>

1.8.3.

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

1.8.4.

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

1.9. Schedule of Events

DHH reserves the right to deviate from the Schedule of Events. DHH will provide the Contractor (60) days advance notice of any changes that may be required in the Health Plan's Readiness Review and/or enrollment schedule.

Schedule of Events

Event	Tentative Schedule
Public Notice of RFP	Tuesday, December 18, 2012
Systems and Technical Conference	Wednesday, December 26, 2012 10:00 a.m. – 11:30 a.m. DHH Bienville Building Room 173 628 4 th Street Baton Rouge, Louisiana 70802
Deadline for Receipt of Written Questions	Thursday, December 27, 2012
Deadline for Receipt of Letter of Intent to Propose	Friday, December 28, 2012

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Deadline for DHH Responses to Written Questions	Wednesday, January 2, 2013
Deadline for Receipt of Written Proposals	Thursday, January 17, 2013 4:00 p.m. CT
Proposal Evaluation Begins	Friday, January 18, 2013
Contract Award Announced	Tuesday, January 22, 2013
Contract Negotiations Begin	Tuesday, January 22, 2013
Contracts Signed by Contractor and DHH (Subject to OCR and CMS Approval)	Monday, January 28, 2013
Contracts Submitted to DOA/OCR for Approval	Wednesday, January 30, 2013
Readiness Reviews Begin	Thursday, January 31, 2013
Network Adequacy Documentation Deadline	Thursday, February 7, 2013
Contractor Network & Contract Submitted to CMS for Approval	Friday, February 8, 2013
Deadline for Completion of On-Site Readiness Review	Friday, February 15, 2013
Deadline for Contractor Network Provider Directory Published to Provider Website	Friday, February 15, 2013
CMS Approval for Contractor Network and Contract	Friday, March 1, 2013
"Go Live" Date	Friday, March 1, 2013

1.10. RFP Addenda

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

<http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/pubMain.cfm> , and

<http://www.makingmedicaidbetter.com> and may also be posted at

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

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

2. Scope of Work

2.1. Requirements for Health Plan

In order to participate as a network for dental services, the Health Plan must:

- meet the federal definition of a PAHP (Prepaid Ambulatory Health Plan) as defined in 42 CFR §438;
- have a license or certificate of authority issued by the Louisiana Department of Insurance (DOI) to operate as a Medicaid risk bearing "prepaid entity" pursuant to Title 22:1016 of the Louisiana Revised Statutes no later than March 1, 2013, and submit to DHH at the time the Health Plan signs the contract with DHH;
- be certified by the Louisiana Secretary of State, pursuant to R.S. 12:24, to conduct business in the state, and submit to DHH at the time the Health Plan signs the Contract with DHH;
- meet solvency standards as specified in 42 CFR 438.116 for a MCO and Title 22 of the Louisiana Revised Statutes;
- have a network capacity to enroll a minimum of 627,000 Medicaid members into the network;
- not have an actual or perceived conflict of interest that, in the discretion of DHH, would interfere or give the appearance of possibly interfering with its duties and obligations under this Contract or any other contract with DHH, and any and all appropriate DHH written policies. Conflict of interest shall include, but is not limited to, being the Medicaid fiscal intermediary contractor for the Department;
- be a successful proposer, be awarded a contract with DHH, and successfully complete the Readiness Review prior to the start date of operations;

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- be able to provide core benefits and services to all assigned members on the day the Dental Benefit Program is implemented.

2.2. DBP Project Overview

2.2.1.

The Health Plan is a risk-bearing, PAHP healthcare delivery system responsible for providing specified Medicaid dental benefits and services included in the Louisiana Medicaid State Plan to Medicaid FFS recipients, Bayou Health Shared Savings Plan and Bayou Health Prepaid Health Plan members.

2.2.2. Contract Term

Services are scheduled to begin March 1, 2013. (See Schedule of Events). The contract term will be from March 1, 2013 through January 31, 2014. The State shall have two (2) one year options for renewal beginning February 1 of each year, after the first year. Renewal is contingent upon successful proposer's performance and availability of funds. Contract awards will consist of the issuance of a Notice of Award document and renewals will be accomplished through the issuance of Renewal Letters or Notice of Award Amendments.

2.2.3.

Management services shall include but are not limited to:

- Utilization Management
- Quality Management and Compliance
- Prior Authorization
- Provider Monitoring
- Member and Provider Services
- Fraud and Abuse Monitoring and Compliance
- Account Management

2.3. General DBPM Requirements

2.3.1.

As required in 42 CFR 455.104(a), the Health Plan shall provide DHH with full and complete information on the identity of each person or corporation with an ownership interest of 5% or greater in the Health Plan, or any subcontractor in which the Health Plan has 5% or more ownership interest. This information shall be provided to DHH on the approved Disclosure Form and whenever changes in ownership occur.

2.3.2.

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

The Health Plan's administrative office shall maintain normal business hours of 8:00 a.m. to 5:00 p.m. CT Monday through Friday.

2.3.3.

The Health Plan shall maintain appropriate personnel to respond to administrative inquiries on business days. The DBPM must respond to calls within one (1) business day.

2.3.4.

The Health Plan shall comply with all current state and federal statutes, regulations, and administrative procedures that are or become effective during the term of this Contract. Federal regulations governing contracts with PAHPs are specified in 42 CFR Part §438 and will govern this Contract. DHH is not precluded from implementing any changes in state or federal statutes, rules or administrative procedures that become effective during the term of this Contract and will implement such changes pursuant to Section 23, Terms and Conditions.

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2.3.5.

The Health Plan must maintain policy and procedures concerning advance directives with respect to all adult individuals receiving dental services by or through the Health Plan in accordance with 42 CFR 422 §422.128, 42 CFR §489.100, and 42 CFR §438.6(i)(2). The written information provided by the Health Plan must reflect any changes in Louisiana law as soon as possible, but no later than ninety (90) days after the effective date of the change.

2.3.6.

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

2.3.7.

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

2.4. Insurance Requirements

2.4.1. General Insurance Information

2.4.1.1.

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

2.4.1.2.

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

2.4.1.3.

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

2.4.1.4.

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

2.4.1.5.

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

2.4.2. Workers' Compensation Insurance

2.4.2.1.

The Health Plan shall obtain and maintain during the life of the Contract, Workers' Compensation Insurance for all of the Health Plan's employees that provide services under the Contract.

2.4.2.2.

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

2.4.2.3.

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

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2.4.2.4.

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

2.4.2.5.

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

2.4.3. Commercial Liability Insurance

2.4.3.1.

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

2.4.3.2.

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

2.4.3.3.

In the absence of specific regulations, the amount of coverage shall be as follows: Commercial General Liability Insurance, including bodily injury, property damage and contractual liability, with combined single limits of \$1,000,000.

2.4.4. Reinsurance

2.4.4.1.

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

2.4.4.2.

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

2.4.4.3.

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

2.4.4.4.

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

2.4.5. Errors and Omissions Insurance

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

2.4.6. Insurance Covering Special Hazards

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

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2.4.7. Licensed and Non-Licensed Motor Vehicles

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

2.4.8. Subcontractor's Insurance

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

2.5. Bond Requirements

2.5.1. Performance Bond or Substitute

2.5.1.1.

The Health Plan shall be required to establish and maintain a performance bond of in the amount of 10% of the annual contract amount for as long as the Health Plan has Contract-related liabilities of \$50,000 or more outstanding, or 15 months following the termination date of this contract, whichever is later, to guarantee: (1) payment of the Contractor's obligations to DHH and (2) performance by the Health Plan of its obligations under this contract [42 CFR §438.116].

2.5.1.2.

The bond must be obtained from an agent appearing on the United States Department of Treasury's list of approved sureties. The performance bond must be made payable to the state of Louisiana. The contract and dates of performance must be specified in the performance bond. The original performance bond must be submitted to DHH. The original performance bond will have the raised engraved seal on the bond and on the Power of Attorney page. The Health Plan must retain a photocopy of the performance bond.

2.5.1.3.

In the event that DHH exercises an option to renew the Contract for an additional period, the Health Plan shall be required to maintain the validity and enforcement of the bond for the specified period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of Contract renewal.

2.5.1.4.

In the event of a default by the Health Plan, DHH may, in addition to any other remedies it may have under this Contract, obtain payment under the performance bond or substitute security for the purposes of the following:

- Paying any damages because of a breach of the Health Plan's obligations under this Contract;
- Reimbursing DHH for any payments made by DHH on behalf of the Health Plan; and
- Reimbursing DHH for cost incurred due to the Health Plan not meeting its obligation under the contract's terms and conditions in under this Contract, including, but not limited to, expenses incurred after termination of this Contract for reasons other than the convenience of the state by DHH.

2.5.1.5.

The Health Plan shall not leverage the bond for another loan or create other creditors using the bond as security.

2.5.1.6.

As an alternative to the Performance Bond, DHH, at the request of the Health Plan and acceptance by DHH, may secure a retainage from capitation payments under the Contract as surety for performance. The retainage amount over the initial twelve (12) month period must equal the amount of the bond. On successful completion of Contract deliverables, the retainage amount may be released on an annual basis. Within ninety (90) days of the termination of the contract, if the contractor has performed the contract services to the satisfaction of the Department and all invoices appear to be correct, DHH shall release all retained amounts to the contractor.

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2.5.2. Fidelity Bond

2.5.2.1.

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

2.5.2.2.

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

3. Eligibility

3.1. Mandatory DBP Populations

The Health Plan will serve Medicaid FFS, Bayou Health Shared Savings Plan and Bayou Health Prepaid Health Plans members in the following categories. The Health Plan shall provide benefits to these groups as described in Section 6.1, General Provisions.

3.1.1. Group A

As specified in LAC 50:XV.6901, Medicaid recipients who are under 21 years of age;

3.2. Excluded DBP Populations

Medicaid Groups that are excluded and will continue to receive their dental services through the FFS program include:

3.2.1.

Individuals who are 21 years of age and older; and

3.2.2.

Individuals residing in out-of-state facilities.

4. Staff Requirements and Support Services

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

For the purposes of this RFP, the Health Plan shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR 438.610(a) and (b), 42 CFR 1001.1901(b), 42 CFR 1003.102(a)(2)]. The Health Plan must screen all employees and sub-contractors to determine whether any of them have been excluded from participation in federal healthcare programs. The HHS-OIG website, which can be searched by the names of any individual, can be accessed at the following URL:

<http://www.oig.hhs.gov/fraud/exclusions.asp>

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

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

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

The Health Plan shall remove or reassign, upon written request from DHH, any Health Plan employee or subcontractor employee that DHH deems to be unacceptable.

4.1. Key Staff Positions

4.1.1.

An individual staff member shall not occupy more than two of the key staff positions listed below unless prior approval is obtained by DHH or otherwise stated below.

4.1.2.

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

4.1.3.

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

4.1.4.

The Health Plan shall replace any of the key staff with a person of equivalent experience, knowledge and talent, within thirty (30) calendar days of resignation/termination of previous staff. The name and resume of the permanent employee shall be submitted, within five (5) business days of the new hire taking place along with a revised organization chart complete with key staff time allocation.

4.1.5.

Replacement of the Administrator/CEO/COO or Dental Director/CMO shall require or prior written approval from DHH (i.e. Bayou Health Director) which shall not be unreasonably withheld provided a suitable candidate is proposed.

4.1.6.

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

4.1.6.1.

Administrator/CEO/COO or their designee must serve in a full time (40 hours weekly) position available during DHH working hours to fulfill the responsibilities of the position and to oversee the entire operation of the Health Plan. The Administrator shall devote sufficient time to the Health Plan's operations to ensure adherence to program requirements and timely responses to DHH.

4.1.6.2.

Dental Director/CMO shall be a Louisiana resident dentist with a current, unencumbered and unrestricted license through the Louisiana State Board of Dentistry. The Dental Director shall devote full time (minimum 32 hours weekly) to the Health Plan's operations to ensure timely dental decisions, including after-hours consultation as needed. During periods when the Dental Director is not available, the Health Plan shall have medical staff to provide competent medical direction. The Dental Director shall be actively involved in all major clinical and quality management components of the Health Plan. The Dental Director shall be responsible for:

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- Development, implementation and dental interpretation of dental policies and procedures including, but not limited to, service authorization, claims review, discharge planning, credentialing and referral management, and dental review included in the Grievance System;
- Administration of all dental management activities of the Health Plan; and
- Serve as director of the Utilization Management committee and chairman or co-chairman of the Quality Assessment and Performance Improvement committee.

4.1.6.3.

Chief Financial Officer/CFO shall oversee the budget, accounting systems and financial reporting implemented by the Health Plan

4.1.6.4.

Compliance Officer must be qualified by training and experience in healthcare or risk management, to oversee a fraud and abuse program to prevent and detect potential fraud and abuse activities pursuant to state and federal rules and regulations, and carry out the provisions of the compliance plan, including fraud and abuse policies and procedures, investigating unusual incidents and implementing any corrective action plans.

4.1.6.5.

Grievance Coordinator shall coordinate member and provider disputes arising under the Grievance System including member grievances, appeals and requests for State Fair Hearings, and provider claim disputes.

4.1.6.6.

Contract Compliance Officer shall serve as the primary point-of-contact for all Health Plan operational issues. The primary functions of the Contract Compliance Officer may include but are not limited to coordinating the tracking and submission of all contract deliverables; fielding and coordinating responses to DHH inquiries, coordinating the preparation and execution of contract requirements, random and periodic audits and ad hoc visits.

4.1.6.7.

Quality Management Coordinator shall be a Louisiana-licensed registered nurse, hygienist, dentist, or a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Healthcare Quality (NAHQ) and/or Certified in Healthcare Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers. The QM Coordinator must have experience in quality management and quality improvement as specified in 42 CFR §§438.200 – 438.242. The primary functions of the Quality Management Coordinator position are:

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

4.1.6.8.

Performance/Quality Improvement Coordinator who has a minimum qualification as a CPHQ or CHCQM or comparable education and experience in data and outcomes measurement as specified in 42 CFR §§438.200 – 438.242. The primary functions of the Performance/Quality Improvement Coordinator are:

- Focusing organizational efforts on improving clinical quality performance measures
- Developing and implementing performance improvement projects
- Utilizing data to develop intervention strategies to improve outcome
- Reporting quality improvement/performance outcomes

4.1.6.9.

Medical Management Coordinator who is a Louisiana-licensed dentist if required to make medical necessity determinations; or have a Master's degree in health services, healthcare administration, or business administration if not required to make

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medical necessity determinations, to manage all required Medicaid management requirements under DHH policies, rules and the contract. The primary functions of the Medical Management Coordinator are:

- Ensuring adoption and consistent application of medical necessity criteria;
- Developing, implementing and monitoring the provision of care coordination, disease management and case management functions;
- Monitoring, analyzing and implementing appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services; and
- Monitoring prior authorization functions and assuring that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards.

4.1.6.10.

Provider Services Manager to coordinate communications between the Health Plan and its members. There shall be sufficient Member Services staff to enable members to receive prompt resolution of their problems or inquiries, and appropriate education about participation in the DBP.

4.1.6.11.

Member Services Manager to coordinate communications between the Health Plan and its members. There shall be sufficient Member Services staff to enable members to receive prompt resolution of their problems or inquiries, enrollment counseling and assistance regarding proactive selection of a primary care dentist, and appropriate education about participation in the DBP.

4.1.6.12.

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

- Developing and implementing claims processing systems capable of paying claims in accordance with state and federal requirements and the terms of the Contract
- Developing processes for cost avoidance;
- Ensuring minimization of claims recoupments;
- Meeting claims processing timelines;
- Meeting DHH encounter reporting requirements.

4.1.6.13.

Provider Claims Educator must be full-time (forty [40] hours per week) employee. This position is fully integrated with the Health Plan's grievance, claims processing, and provider relations systems and facilitates the exchange of information between these systems and providers, with a minimum of five (5) years management and supervisory experience in the healthcare field. The primary functions of the Provider Claims Educator are:

- Educating in-network and out-of-network providers (i.e., dental, professional, and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available DBP resources such as provider manuals, websites, fee schedules, etc.;
- Interfacing with the DBPM's call center to compile, analyze, and disseminate information from provider calls;
- Identifying trends and guiding the development and implementation of strategies to improve provider satisfaction;
- Frequently communicating (i.e., telephonic and on-site) with providers to ensure the effective exchange of information and to gain feedback regarding the extent to which providers are informed about appropriate claims submission practices;

4.1.6.14.

Information Management and Systems Director shall be trained and experienced in information systems, data processing and data reporting to oversee all Health Plan information systems functions including, but not limited to, establishing and maintaining connectivity with DHH information systems and providing necessary and timely reports to DHH.

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4.1.7. Additional Required Staff

4.1.7.1.

Prior Authorization Staff to authorize healthcare 8 hours per day, 7 days per week. This staff shall include and must work under the direction of the Dental Director.

4.1.7.2.

Clerical and Support Staff to ensure proper functioning of the Health Plan's operation.

4.1.7.3.

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

4.1.7.4.

Member Services Staff to enable members to receive prompt responses and assistance. There shall be sufficient Member Services staff to enable members and potential members to receive prompt resolution of their problems or inquiries, enrollment counseling and assistance regarding proactive selection of a primary care dentist, and appropriate education about participation in the DBP.

4.1.7.5.

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

4.1.7.6.

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

4.2. In-State Positions

The Health Plan shall maintain a significant local (within the state of Louisiana) presence. Significant shall be defined as over fifty percent (50%) of full time equivalent FTE whose responsibilities are primarily dedicated to the LA Health Plan. Positions that shall be located in Louisiana are the following:

- Administrator/CEO/COO
- Dental Director/CMO
- Compliance Officer
- Grievance Coordinator
- Contract Compliance Officer
- Quality Management Coordinator
- Medical Management Coordinator
- Provider Services Manager
- Provider Claims Educator (if applicable)

4.3. Written Policies, Procedures, and Job Descriptions

4.3.1.

The Health Plan shall develop and maintain written policies, procedures and job descriptions for each functional area, consistent in format and style. The Health Plan shall maintain written guidelines for developing, reviewing and approving all policies, procedures and job descriptions. All policies and procedures shall be reviewed at least annually to ensure that the Health Plan's written policies reflect current practices. Reviewed policies shall be dated and signed by the Health Plan's appropriate manager, coordinator, director or administrator. Minutes reflecting the review and approval of the policies by an appropriate committee are also acceptable documentation. All medical and quality management policies must be approved and signed by the Health Plan's Medical Director. Job descriptions shall be reviewed at least annually to ensure that current duties performed by the employee reflect written requirements.

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4.3.2.

Based on provider or member feedback, if DHH deems a Health Plan policy or process to be inefficient and/or places an unnecessary burden on the members or providers, the Health Plan shall be required to work with DHH to change the policy or procedure within a time period specified by DHH.

4.4. Staff Training and Meeting Attendance

4.4.1.

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

4.4.2.

The Health Plan must provide initial and ongoing staff training that includes an overview of DHH, Medicaid Policy and Procedure Manuals, and Contract and state and federal requirements specific to individual job functions. The Health Plan shall ensure that all staff members having contact with members or providers receive initial and ongoing training with regard to the appropriate identification and handling of quality of care/service concerns.

4.4.3.

New and existing prior authorization and member services representatives must be trained in the geography of Louisiana and have access to mapping search engines (e.g. MapQuest, Yahoo Maps, Google Maps, etc.) for the purposes of authorizing services in; recommending providers in; and transporting members to the most geographically appropriate location.

4.4.4.

The Health Plan shall provide the appropriate staff representation for attendance and participation in meetings and/or events scheduled by DHH. All meetings shall be considered mandatory unless otherwise indicated.

4.4.5.

DHH reserves the right to attend any and all training programs and seminars conducted by the Health Plan. The Health Plan shall provide DHH a list of any marketing training dates (See Section 12, Marketing and Member Materials), time and location, at least fourteen (14) calendar days prior to the actual date of training.

4.5. Annual Reporting to DHH

The Health Plan must submit to the DHH the following items annually or upon request:

- An updated organization chart complete with the Key Staff positions. The chart must include the person's name, title and telephone number and portion of time allocated to the Louisiana Medicaid contract, other Medicaid contracts, and other lines of business.
- A functional organization chart of the key program areas, responsibilities and the areas that report to that position.
- A listing of all functions and their locations; and a list of any functions that have moved outside of the state of Louisiana in the past contract year.

5. Health Plan Reimbursement

DHH shall make monthly capitated payments for each member enrolled into the Health Plan.

The Health Plan agrees to accept payment in full and shall not seek additional payment from a member for any unpaid cost.

DHH reserves the right to defer remittance of the PMPM payment for June until the first Medicaid Management Information System (MMIS) payment cycle in July to comply with state fiscal policies and procedures.

In the event the federal government lifts any moratorium on supplemental payments to dentists or facilities, PMPM rates in the Contract may be adjusted accordingly.

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5.1. DBP Payment Schedule

5.1.1.

The monthly capitated payment shall be based on Medicaid recipients eligible for Health Plan participation during the month and paid in the weekly payment cycle nearest the 15th calendar day of the month (see Appendix L – Fiscal Intermediary (FI) Payment Schedule).

5.1.1.1.

The Health Plan shall make payments to its providers as stipulated in the contract.

5.1.1.2.

The Health Plan shall not assign its right to receive payment to any other entity.

5.1.1.3.

Payment for items or services provided under this contract shall not be made to any entity located outside of the United States including the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

5.1.1.4.

The Health Plan 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 Health Plan.

5.2. Payment Adjustments

5.2.1.

In the event that an erroneous payment is made to the Health Plan, DHH shall reconcile the error by adjusting the Health Plan's future monthly capitation payment.

5.2.2.

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

5.2.3.

The Health Plan shall refund payments received from DHH for a deceased member effective the month of service after the month of death. DHH will recoup the payment as specified in the contract.

5.2.4.

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

5.3. Rate Adjustments

DHH reserves the right to re-negotiate the PMPM rates:

- If the rate floor is removed, or
- If a result of federal or state budget reductions or increase, or
- If due to the inclusion or removal of a covered Medicaid service(s) not incorporated in the monthly capitation rate.

The rates may also be adjusted due to the inclusion or removal of a covered Medicaid service(s) not incorporated in the monthly capitation rate; and/or based on legislative appropriations and budgetary constraints. Any adjusted rates must continue to be actuarially sound and will require an amendment to the Contract that is mutually agreed upon by both parties.

5.4. Medical Loss Ratio

The Health Plan shall provide an annual Medical Loss Ratio (MLR) report by June 1 following the end of the MLR reporting year, which shall be a calendar year. If the MLR (cost for healthcare benefits and services and specified quality expenditures) is less than 85%, the Health Plan shall refund DHH the difference by August 1 following the end of the reporting year. Any unpaid balances after August 1 shall be subject to interest of 10% per annum. See Appendix D – MLR (Medical Loss Ratio) Calculation Methodology for MLR calculation methodology and classification of costs).

5.5. Copayments

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

5.6. Return of Funds

5.6.1.

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

5.6.2.

The Health Plan shall reimburse all payments as a result of any federal disallowances or sanctions imposed on DHH as a result of the Health Plan's failure to abide by the terms of the Contract. The Health Plan shall be subject to any additional conditions or restrictions placed on DHH by the United States Department of Health and Human Services (HHS) as a result of the disallowance. Instructions for returning of funds shall be provided by written notice.

5.7. Third Party Liability (TPL)

5.7.1. General TPL Information

5.7.1.1.

Pursuant to federal and state law, the Medicaid program by law is intended to be the payer of last resort. This means all other available Third Party Liability resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

5.7.1.2.

The Health Plan shall take reasonable measures to determine Third Party Liability.

5.7.1.3.

The Health Plan shall coordinate benefits in accordance with 42 CFR §433.135 et seq. and Louisiana Revised Statutes, Title 46, so that costs for services otherwise payable by the Health Plan are cost avoided or recovered from a liable party. The two methods used are cost avoidance and post-payment recovery. The Health Plan shall use these methods as described in federal and state law.

5.7.1.4.

Establishing Third Party Liability takes place when the Health Plan receives confirmation that another party is, by statute, contract, agreement, or otherwise, legally responsible for the payment of a claim for a healthcare item or services delivered to a member.

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5.7.1.5.

If the probable existence of Third Party Liability cannot be established the Health Plan must adjudicate the claim. The Health Plan must then utilize post-payment recovery which is described in further detail below.

5.7.1.6.

The term "state" shall be interpreted to mean "Health Plan" for purposes of complying with the federal regulations referenced above. The Health Plan may require subcontractors to be responsible for coordination of benefits for services provided pursuant to this contract.

5.7.2. Cost Avoidance

5.7.2.1.

Unless prohibited by applicable federal or state law or regulations, The Health Plan shall cost-avoid a claim if it establishes the probable existence of Third Party Liability at the time the claim is filed.

5.7.2.2.

The Health Plan shall bill the private insurance within sixty (60) days from date of discovery of coverage.

5.7.2.3.

The Health Plan shall adjudicate claims for medical treatment associated with EPSDT in accordance with federal and state law.

5.7.3. Post-payment Recoveries

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

5.7.3.1.

The Health Plan must have established procedures for recouping post-payments for DHH's review during the Readiness Review process. The Health Plan must void encounters for claims that are recouped in full. For recoupments that result in an adjusted claim value, the Health Plan must submit replacement encounters.

5.7.3.2.

The Health Plan shall identify the existence of potential Third Party Liability to pay for core benefits and services through the use of trauma code edits, utilizing diagnostic codes 800 through 999.9 (excluding code 994.6) and any other applicable trauma codes, including but not limited to E Codes in accordance with 42 CFR 433.138(e).

5.7.3.3.

The Health Plan must report the existence of Third Party Liability, to the DHH contracted vendor within 5 business days from identifying the coverage.

5.7.3.4.

The Health Plan shall be required to seek reimbursement in accident/trauma related cases when claims in the aggregate equal or exceed \$500 as required by the Louisiana Medicaid State Plan and federal Medicaid guidelines and may seek reimbursement when claims in the aggregate or less than \$500

5.7.3.5.

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

5.7.3.6.

Prior to accepting a Third Party Liability settlement on claims equal to or greater than \$25,000, the Health Plan shall obtain approval from DHH.

The Health Plan may retain up to 100% of its Third Party Liability collections if all of the following conditions exist:

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

5.7.3.7.

DHH will utilize the data in calculating future capitation rates.

5.7.4. TPL Reporting Requirements

5.7.4.1.

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

5.7.4.2.

The Health Plan shall be required to include the collections and claims information in the encounter data submitted to DHH, including any retrospective findings via encounter adjustments.

5.7.4.3.

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

5.7.4.4.

The Health Plan shall report members with third party coverage to DHH on a monthly basis within 5 business days from identifying the coverage.

5.7.4.5.

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

5.7.4.6.

The Health Plan must submit an annual report of all health insurance collections for its members plus copies of any Form 1099's received from insurance companies for that period of time.

5.7.5. DHH Right to Conduct Identification and Pursuit of TPL

5.7.5.1.

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

5.7.5.2.

If DHH determines the Health Plan is not actively engaged in cost avoidance the Health Plan will be responsible for all administrative costs associated with this DHH's collection activities under Section 5.9.5.1.

5.8. Coordination of Benefits

5.8.1. Other Coverage Information

The Health Plan shall maintain other coverage information for each member. The Health shall verify the other coverage information provided by DHH pursuant to Section 5.7 and develop a system to include additional other coverage information when it becomes available. The Health Plan shall provide a periodic file of updates to other coverage back to the state.

5.8.2. Cost Avoidance

As Provided in Section 5.7.2, except in certain cases, the Health Plan shall attempt to avoid payment in all cases where there is other insurance (Medicaid is payer of last resort).

5.8.3. Post-Payment Recoupment

As provided in Section 5.7.3, Health Plan shall initiate a post payment recovery process when it is determined after the fact that the member had other coverage at the time of service.

5.8.4. Reporting and Tracking

The Health Plan's system shall identify and track potential collections. The System should produce reports indicating open receivables, closed receivables, amounts collected, amounts written off and amounts avoided.

5.9. Copays

5.9.1. Requirements

The Health Plan and its subcontractors are not required to impose any copay requirements on their members. The Health Plan and its subcontractors however, are not permitted to charge their members fees of any kind or any copay amount above what exists in the Medicaid State Plan.

6. Core Benefits and Services

6.1. General Provisions

6.1.1.

The Health Plan shall provide members, at a minimum, with those core benefits and services specified in the Contract and as defined in the Louisiana Medicaid State Plan, administrative rules and Medicaid Policy and Procedure manuals. The Health Plan shall possess the expertise and resources to ensure the delivery of quality healthcare services to Health Plan members in accordance with Louisiana Medicaid program standards and the prevailing dental community standards.

6.1.2.

The Health Plan shall provide a mechanism to reduce inappropriate and duplicative use of healthcare services. Services shall be furnished in an amount, duration, and scope that is not less than the amount, duration, and scope for the same services furnished to eligibles under FFS Medicaid, as specified in 42 CFR §§438.210(a)(1) and (2). Upward variances of amount, duration and scope of these services are allowed.

6.1.3.

Although the Health Plan shall provide the full range of required core benefits and services listed below, it may choose to provide services over and above those specified when it is cost effective to do so. The Health Plan may offer additional benefits that are outside the scope of core benefits and services to individual members on a case-by-case basis, based on medical necessity, cost-effectiveness, the wishes of the member and/or member's family, the potential for improved health status of the member, and functional necessity.

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6.1.4.

If new services are added to the Louisiana Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contract shall be amended and the Department will make every effort to give the Health Plan sixty (60) days advance notice of the change. However, the Health Plan shall add, delete, or change any service as may be deemed necessary by DHH within the timeframe required by DHH if mandated by federal or state legislation or court order.

Louisiana Medicaid State Plan Services (Appendix E) provides a general overview of Louisiana Medicaid services, which are identified as either federally mandated or state legislatively approved optional services.

6.1.5.

6.1.5.1.

The Health Plan shall provide core benefits and services to Medicaid members based on their eligibility group as specified by DHH in Section 3 of this RFP for the eligibility groups.

6.1.5.1.1. Group A

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

- **Diagnostic Services** which include oral examinations, radiographs and oral/facial images, diagnostic casts and accession of tissue – gross and microscopic examinations;
- **Preventive Services** which include prophylaxis, topical fluoride treatments, sealants, fixed space maintainers and re-cementation of space maintainers;
- **Restorative Services** which include amalgam restorations, composite restorations, stainless steel and polycarbonate crowns, stainless steel crowns with resin window; pins, core build-ups, pre-fabricated posts and cores, resin-based composite restorations, appliance removal, and unspecified restorative procedures;
- **Endodontic Services** which include pulp capping, pulpotomy, endodontic therapy on primary and permanent teeth (including treatment plan, clinical procedures and follow-up care), apexification/recalcification, apicoectomy/periradicular services and unspecified endodontic procedures;
- **Periodontal Services** which include gingivectomy, periodontal scaling and root planning, full mouth debridement, and unspecified periodontal procedures;
- **Removable Prosthodontics** services which include complete dentures, partial dentures, denture repairs, denture relines and unspecified prosthodontics procedures;
- **Maxillofacial Prosthetics** service;
- **Fixed Prosthodontics** services which include fixed partial denture pontic, fixed partial denture retainer and other unspecified fixed partial denture services;
- **Oral and Maxillofacial Surgery** services which include non-surgical extractions, surgical extractions, coronal remnants extractions, other surgical procedures, alveoloplasty, surgical incision, temporomandibular joint (TMJ) procedure and other unspecified repair procedures;
- **Orthodontic Services** which include interceptive and comprehensive orthodontic treatments, minor treatment to control harmful habits and other orthodontic services; and
- **Adjunctive General Services** which include palliative (emergency) treatment, anesthesia, professional visits, miscellaneous services, and unspecified adjunctive procedures.

6.1.6.

The Health Plan shall ensure that services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.

6.1.7.

The Health Plan shall not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the member.

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6.1.8.

The Health Plan may place appropriate limits on a service (a) on the basis of certain criteria, such as medical necessity; or (b) for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

6.1.9.

The Health Plan may exceed the service limits as specified in the Louisiana Medicaid State Plan to the extent that those service limits can be exceeded with authorization in FFS. No dental service limitation can be more restrictive than those that currently exist under the Louisiana Medicaid State Plan.

6.1.10.

The Health Plan may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care.

6.1.11.

The Health Plan shall not portray core benefits or services as an expanded health benefit.

6.2. Laboratory and Radiological Services

6.2.1.

The Health Plan shall provide outpatient diagnostic testing and radiological services ordered and/or performed by all network providers.

6.2.2.

The Health Plan may require service authorization for diagnostic testing and radiological services ordered or performed by any provider for their members.

6.3. EPSDT

6.3.1.

In accordance with 42 CFR §441.56(b)(1)(vi) and periodicity charts posted on Louisiana Medicaid's website at www.lamedicaid.com, the Health Plan shall provide dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age.

6.3.2.

In accordance with 42 CFR §441.56(c)(2), the Contractor shall provide dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

6.3.3.

The Health Plan shall accurately report, via encounter data submissions all dental screenings and access to preventive services as required for DHH to comply with federally mandated CMS 416 reporting requirements (Appendix X – EPSDT Reporting). See Health Plan Systems Companion Guide for format and timetable for reporting of EPSDT data. Instructions on how to complete the CMS 416 report may be found on CMS's website at:

http://www.cms.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp#TopOfPage

6.4. Emergency Dental Services

The Health Plan shall make provisions for and advise all members of the provisions governing emergency use pursuant to 42 CFR §438.114. Emergency-related definitions are in the Glossary, of this RFP. Requirements for the Health Plan to provide emergency and post-stabilization services are as follows:

6.4.1.

The Health Plan shall cover services as described in Section 6.1.5. Provision of these services in an emergency or post-stabilization context broadens the Health Plan's responsibilities to include payment for these services to out-of-net providers as described in this section.

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6.4.2.

The Health Plan shall be responsible for dental related services provided in an emergency context other than those described in Section 6.1.5.

6.4.3.

In providing for emergency services and care as a covered service, the Health Plan shall not:

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

6.4.4.

When a member is present at a hospital seeking emergency services and care, the determination as to whether an emergency dental condition (provided in the Glossary) exists shall be made, for the purpose of treatment, by a dentist or a dentist of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of the hospital dentist. The dentist or the appropriate personnel shall indicate in the patient’s chart the results of the screening, examination, and evaluation. The Health Plan shall compensate the dental provider for any dental services that are incidental to the screening, evaluations, and examination that are reasonably calculated to assist the health care provider in arriving at a determination as to whether the patient’s condition is an emergency dental condition. The Health Plan shall compensate the dental provider for emergency dental services and care. If a determination is made that an emergency dental condition did not exist and that an emergency medical condition was not apparent under the prudent layperson standard, the Health Plan is not responsible for payment for services rendered subsequent to that determination.

6.4.5.

The Health Plan shall not deny payment for emergency services and care.

6.4.6.

The Health Plan shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member’s primary care dentist of the member’s screening and treatment within one (1) business day of presentation for emergency services.

6.4.7.

The Health Plan shall not deny payment for treatment when a representative of the entity instructs the member to seek emergency services.

6.4.8.

The Health Plan shall not deny payment for treatment obtained when a member had an emergency dental condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of an emergency medical condition.

6.4.9.

The Health Plan shall not limit what constitutes an emergency dental condition on the basis of lists of diagnoses or symptoms.

6.4.10.

The hospital-based provider and the primary care dentist may discuss the appropriate care and treatment of the member. Notwithstanding any other state law, a hospital may request and collect insurance or financial information from a patient in accordance with federal law to determine if the patient is a member of the Health Plan, if emergency services and care are not delayed.

6.4.11.

The Health Plan shall not deny emergency services claims submitted by a non-contracting provider solely based on the period between the date of service and the date of clean claim submission unless that period exceeds 365 days.

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6.4.12.

If third party liability exists, payment of claims shall be determined in accordance with Section 5.7, Third Party Liability (TPL).

6.4.13.

The Health Plan must review and approve or disapprove emergency service claims based on the definition of emergency services and care specified in Section 24, Glossary.

6.4.14.

The Department will conduct an annual audit of outpatient claims. If the audit of Emergency Room claims reveals an increase (compared to previous state fiscal year or contract period) in Medicaid fee-for-service utilization for dental related services, the Department may request a corrective action plan. Also, fraud and abuse investigations may be conducted including administrative action and recoupment.

6.5. Dental Services for Special Populations

6.5.1. Individuals with Special Healthcare Needs

6.5.1.1.

The Health Plan shall implement mechanisms for identifying, assessing and ensuring the existence of a treatment plan for individuals with special health care needs. Mechanisms shall include evaluation of health risk assessments, claims data, and, if available, CDT, /ICD-9 codes. Additionally, the Health Plan shall implement a process for receiving and considering provider and member input.

6.5.1.2.

In accordance with the Contract and 42 CFR §438.208(c)(3), a treatment plan for a member determined to need a course of treatment or regular care monitoring must be: developed by the member's care provider with member participation and in consultation with any specialists caring for the member; approved by the Health Plan in a timely manner if this approval is required; and developed in accordance with any applicable Department quality assurance and utilization review standards.

6.5.1.3.

Pursuant to 42 CFR §438.208(c)(4), for members with special health care needs determined through an assessment by appropriate health care professionals (consistent with 42 CFR 438.208(c)(2)) to need a course of treatment or regular care monitoring, the Health Plan must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

6.5.2. Individualized Treatment Plans

The individualized treatment plans must be:

- Developed by the member's primary care dentist, with enrollee participation, and in consultation with any specialists caring for the member;
- Approved by the Health Plan in a timely manner if required by the Health Plan; and
- In compliance with applicable QA and UM standards.

6.6. Excluded Services

6.6.1.

The Health Plan is not obligated to provide for the services that are not specified in this RFP. DBP members who require services available through Medicaid but not covered by the Contract shall receive these services through the existing Medicaid fee-for-service reimbursement system or their managed care plan. The Health Plan shall determine the need for these services and refer the member to the appropriate service provider. Services include the following:

6.6.1.1.

Fluoride Varnish services provide by physicians;

6.7. Prohibited Services

6.7.1.

The Health Plan is prohibited from providing Experimental/investigational drugs, procedures or equipment, unless approved by the Secretary of DHH or elective cosmetic surgery.

6.8. Expanded Services/Benefits

6.8.1.

As permitted under 42 CFR §438.6(e), the Health Plan may offer expanded services and benefits to enrolled Medicaid Health Plan members in addition to those core benefits and services specified in this RFP.

6.8.2.

These expanded services may include dental care services which are currently non-covered services by the Louisiana Medicaid State Plan and/or which are in excess of the amount, duration, and scope in the Louisiana Medicaid State Plan.

6.8.3.

These services/benefits shall be specifically defined by the Health Plan in regard to amount, duration and scope. DHH will not provide any additional reimbursement for these services/benefits.

6.8.4.

Transportation for these services/benefits is the responsibility of the member and/or Health Plan, at the discretion of the Health Plan.

6.8.5.

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

6.9. Care Management

6.9.1.

The Health Plan shall be responsible for the management of dental care and continuity of dental care for all members. Pursuant to 42 CFR §438.208(b), the Health Plan must implement procedures to deliver primary dental care to and coordinate health care service for all members. These procedures must:

- Ensure that each member has an ongoing source of primary dental care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the dental health care services furnished to the member.
- Coordinate the dental services the Health Plan furnishes to the member with the services the member receives from any other managed care entity during the same period of enrollment.
- Share with other managed care organizations serving members the results of its identification and assessment of the member's dental needs to prevent duplication of those activities.
- Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Part 160 and 45 CFR Part 164, Subparts A and E (the HIPAA Privacy Rule), to the extent that they are applicable.

6.9.2.

The Health Plan shall maintain written case management continuity of care protocol(s) that include the following minimum functions:

- Appropriate referral of and scheduling assistance for members needing specialty dental care.

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- Documentation of referral services in members' dental records, including results.
- Monitoring of members with ongoing dental conditions and coordination of services for high users such that the following functions are addressed as appropriate: acting as a liaison between the member and providers, ensuring the member is receiving routine dental care, ensuring that the member has adequate support at home, and assisting members who are unable to access necessary care due to their medical or emotional conditions or who do not have adequate community resources to comply with their care.
- Documentation in dental records of member emergency encounters with appropriate indicated follow-up.

7. Provider Network Requirements

7.1. General Provider Network Requirements

7.1.1.

The Health Plan must maintain a network of qualified dental providers in sufficient numbers and locations to provide required access to covered services. The Health Plan is expected to design a network that provides a geographically convenient flow of patients among network providers. The provider network shall be designed to reflect the needs and service requirements of the Health Plan's member population. The Health Plan shall design its dental provider network to maximize the availability of community based primary dental care and specialty dental care access.

7.1.2.

The Health Plan must provide a comprehensive network to ensure its membership has access at least equal to, or better than, community norms. Services shall be accessible to Health Plan members in terms of timeliness, amount, duration and scope as those are available to Medicaid recipients who are not enrolled in the Dental Benefit Program [42 CFR §438.210(a)(2)]. The Health Plan is encouraged to have available non-emergent after-hours primary dental care services within its network. If the network is unable to provide medically necessary services required under contract, the Health Plan shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted. The Health Plan shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR §438.206(b)(4) and (5)].

7.1.3.

There shall be sufficient personnel for the provision of all core benefits and services.

7.1.4.

In accordance with the requirements in this RFP and the members' needs, the proposed network shall be sufficient to provide core benefits and services within designated time and distance limits.

7.1.5.

All providers shall be in compliance with Americans with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities.

7.1.6.

If a current Medicaid provider, (including significant traditional providers (STP), requests participation in Health Plan, the Health Plan should make a good faith effort to execute a contract. In the event an agreement cannot be reached and the provider does not participate in the Health Plan, the Health Plan has met this requirement; the Health Plan shall maintain documentation detailing efforts made.

7.1.7.

The Health Plan shall not discriminate with respect to participation in the Dental Benefit Program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR §§438.12(a)(1) and (2)]. In addition, the Health Plan must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR §438.214(c)].

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7.1.8.

The provision in Section 7.1.6 does not prohibit the Health Plan from limiting provider participation to the extent necessary to meet the needs of the Health Plan's members. This provision also does not interfere with measures established by the Health Plan to control costs and quality consistent with its responsibilities under this contract nor does it preclude the Health Plan from using reimbursement amounts that are less or greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR §438.12(b)(1)].

7.1.9.

If the Health Plan declines requests a provider to be included in the Health Plan network, the Health Plan must give the requested providers written notice of the reason for its decision within fourteen (14) calendar days of its decision [42 CFR §438.12(a)(1)].

7.1.10.

If the Health Plan terminates a provider's contract for cause, the Health Plan shall provide immediate written notice to the provider. The Health Plan shall notify DHH of the termination as soon as possible, but no later than seven (7) calendar days, of written notification of cancellation to the provider.

7.1.11.

The Health Plan shall make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) calendar days after receipt of issuance of the termination notice, to each Health Plan member who received his or her primary dental care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(5).

7.1.12.

The Health Plan's network providers shall comply with all requirements set forth in this RFP.

7.1.13.

The Health Plan shall meet the following requirements:

7.1.13.1.

Ensure the provision of all core benefits and services specified in the Contract. Accessibility of benefits/services, including geographic access, appointments, and wait times shall be in accordance with the requirements in this RFP. These minimum requirements are not intended to release the Health Plan from the requirement to provide or arrange for the provision of any medically necessary covered benefit/service required by its members, whether specified or not.

7.1.13.2.

Provide core services directly or enter into written agreements with providers or organizations that shall provide core services to the members in exchange for payment by the Health Plan for services rendered.

7.1.13.3.

Not execute contracts with individuals or groups of providers who have been excluded from participation in Federal healthcare programs under either section 1128 or section 1128A of the Social Security Act [42 CFR §438.214(d)] or state funded healthcare programs. The list of providers excluded from federally funded healthcare programs can be found at <http://exclusions.oig.hhs.gov/search.aspx> and www.EPLS.gov and Health Integrity and Protection Data Bank at <http://www.npdb-hipdb.hrsa.gov/index.jsp>

7.1.13.4.

Not prohibit, or otherwise restrict, a healthcare professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:

- Member's health status, medical or behavioral healthcare, or treatment options, including any alternative treatment that may be self-administered;
- Information the member needs in order to decide among all relevant treatment options;
- The risk, benefits, and consequences of treatment and non-treatment; or

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- The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

7.1.13.5.

If the Health Plan is unable to meet the geographic access standards for a member, the Health Plan must make transportation available to the member, regardless of whether the member has access to transportation. The Health Plan may be subject to sanctions for inability to meet the geographic access standards set forth in this RFP.

7.1.13.6.

Monitor provider compliance with applicable access requirements, including but not limited to, appointment and wait times, and take corrective action for failure to comply. The Health Plan shall conduct service area review of appointment availability and twenty-four (24) hour access and availability surveys annually. The survey results must be kept on file and be readily available for review by DHH upon request. The Health Plan may be subject to sanctions for noncompliance of providers with applicable appointment and wait time requirements set forth in this RFP.

7.1.13.7.

If a member requests a provider who is located beyond access standards, and the Health Plan has an appropriate provider within the Health Plan who accepts new patients, it shall not be considered a violation of the access requirements for the Health Plan to grant the member's request. However, in such cases the Health Plan shall not be responsible for providing transportation for the member to access care from this selected provider, and the Health Plan shall notify the member in writing as to whether or not the Health Plan will provide transportation to seek care from the requested provider.

7.1.13.8.

The Health Plan shall require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and provide for interpreters in accordance with 42 CFR §438.206.

7.1.13.9.

The Health Plan shall at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted providers. Failure to do so may result in monetary penalties up to \$5,000 per day against the Health Plan; whether the data is clean, current or accurate shall be at the discretion of DHH.

7.2. Mainstreaming

7.2.1.

DHH considers mainstreaming of Health Plan members into the broader health delivery system to be essential. The Health Plan therefore must ensure that all Health Plan providers accept members for treatment and that Health Plan providers do not intentionally segregate members in any way from other persons receiving services. Providers shall not have two separate locations, one for the Medicaid population and another for private pay. Both locations must accept Medicaid recipients who are willing to receive services at either location.

7.2.2.

To ensure mainstreaming of members, the Health Plan shall take affirmative action so that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

7.2.2.1.

Denying or not providing to a member any covered service or availability of a facility.

7.2.2.2.

Providing to a member any covered service which is different, or is provided in a different manner, or at a different time from that provided to other members, other public or private patients, or the public at large.

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7.2.2.3.

Discriminatory practices with regard to members such as separate waiting rooms, separate offices for Medicaid and private pay patients, separate appointment days, or preference to private pay or Medicaid FFS patients.

7.2.3.

If the Health Plan knowingly executes a subcontract with a provider with the intent of allowing or permitting the subcontractor to implement barriers to care (i.e., the terms of the subcontract are more restrictive than the contract), DHH shall consider the Health Plan to have breached the provisions and requirements of the contract. In addition, if the Health Plan becomes aware of any of its existing subcontractors' failure to comply with this section and does not take action to correct this within thirty (30) calendar days, DHH shall consider the Health Plan to have breached the provisions and requirements of the contract.

7.3. Access Standards and Guidelines

The Health Plan shall ensure access to healthcare services (distance traveled, waiting time, length of time to obtain an appointment, after-hours care) in accordance with the provision of services under this RFP. DHH will monitor the Health Plan's service accessibility and may require that the Health Plan obtain services from out-of-network providers as necessary for the provision of core benefits and services. The Health Plan shall provide available, accessible, and adequate numbers of service locations, service sites, and professional, allied and para-medical personnel for the provision of core benefits and services, and shall take corrective action if there is failure to comply by any provider. At a minimum, this shall include:

7.3.1. Distance

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

7.3.1.1. Distance to Primary Care Dentists

Travel distance from member's place of residence shall not exceed forty (40) miles for rural areas and twenty (20) miles for urban areas.

7.3.1.2. Distance to Specialists

7.3.1.2.1.

Travel distance shall not exceed sixty (60) miles from the member's place of residence for at least 75% of members; and

7.3.1.2.2.

Travel distance shall not exceed ninety (90) miles from the member's place of residence for all members.

7.3.1.2.3.

Access standards to specialists that cannot be met may be satisfied utilizing telemedicine with prior DHH approval.

7.4. Scheduling/Appointment Waiting Times

7.4.1.

The Health Plan shall ensure that its network providers have an appointment system for core benefits and services and/or expanded services which are in accordance with prevailing dental community standards as specified below.

7.4.2.

The Health Plan shall have policies and procedures for these appointment standards. Methods for educating both the providers and the members about appointment standards shall be addressed in these policies and procedures. The Health Plan shall disseminate these appointment standard policies and procedures to its in-network providers and to its members. The Health Plan shall monitor compliance with appointment standards and shall have a corrective action plan when appointment standards are not met.

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7.5. Timely Access

The Health Plan shall ensure that medically necessary services are available on a timely basis, as follows:

7.5.1.

Emergent or emergency visits immediately upon presentation at the service delivery site. Emergency services must be available at all times.

7.5.2.

Urgent Care within twenty-four (24) hours; Provisions must be available for obtaining urgent care 24 hours per day, 7 days per week. Urgent care may be provided directly by the primary care dentist or directed by the Health Plan through other arrangements.

7.5.3.

Non-urgent sick care within seventy-two (72) hours or sooner if dental condition(s) deteriorates into an urgent or emergency condition;

7.5.4.

Routine, non-urgent, or preventative care visits within six (6) weeks;

7.5.5.

Specialty care consultation within one (1) month of referral or as clinically indicated;

7.5.6.

Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care or as clinically indicated; and

7.5.7.

Follow-up visits in accordance with ER attending provider discharge instructions.

7.5.8.

In office waiting time for scheduled appointments should not routinely exceed forty-five (45) minutes, including time in the waiting room and examining room.

- Providers may be delayed when they “work in” urgent cases, when a serious problem is found with a previous patient, or when a previous patient requires more services or education than was described at the time the appointment was scheduled. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than ninety (90) minutes, the patient shall be offered a new appointment.
- Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.
- Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.

7.5.9.

The Health Plan shall monitor providers regularly to determine compliance with this Section through such methods as “mystery shopping” and staged scenarios in an effort to reduce the unnecessary use of alternative methods of access to care such as emergency room visits [42 CFR §438.206(c)(1)(i)]; and take corrective action if there is a failure to comply.

7.5.10.

The Health Plan must use the results of appointment standards monitoring to assure adequate appointment availability in order to reduce unnecessary emergency department utilization. The Health Plan is also encouraged to contract with or employ the services of non-emergency facilities to address member non-emergency care issues occurring after regular office hours or on weekends.

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7.5.11.

The Health Plan shall establish processes to monitor and reduce the appointment “no-show” rate for primary care dentists, and transportation providers. As best practices are identified, DHH may require implementation by the Health Plan.

7.5.12.

The Health Plan shall have written policies and procedures about educating its provider network about appointment time requirements. The Health Plan must develop a corrective action plan when appointment standards are not met; if appropriate, the corrective action plan should be developed in conjunction with the provider [42 CFR §438.206(c)(1)(iv), (v) and (vi)]. Appointment standards shall be included in the Provider Manual. The Health Plan is encouraged to include the standards in the provider subcontracts.

7.6. Assurance of Adequate Primary Care Dentist Access and Capacity

7.6.1.

The primary care dentist may practice in a solo or group practice or may practice in a clinic (i.e. Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or outpatient clinic. The Health Plan shall provide at least one (1) full time equivalent (FTE) primary care dentist per five thousand (5,000) Health Plan members. DHH defines a full time primary care dentist as a provider that provides dental care services for a minimum of thirty-two (32) hours per week of practice time. The Health Plan shall require that each individual primary care dentist shall not exceed a total of five thousand (5,000) Medicaid linkages in all Health Plan’s in which the primary care dentist may be a network provider.

7.6.2.

The Health Plan shall provide access to primary care dentists that offer extended office hours (minimum of 2 hours) at least one day per week (before 8:00 am and after 4:30 pm) and on Saturdays, within sixty (60) miles of a member’s residence for urgent care.

7.6.3.

Network providers must offer office hours at least equal to those offered to the Health Plan’s Medicaid FFS participants, if the provider accepts only Medicaid patients.

7.6.4.

Within thirty (30) calendar days after implementation of the Health Plan and monthly thereafter, the Health Plan shall provide on or before the first of each month the primary care dentist with a report (electronic or hard copy) of all members linked to their practice.

7.7. Primary Care Dentist Responsibilities

The Health Plan shall establish policies pertaining to the primary care dentist’s responsibilities that address, at a minimum, the following:

- Coordinating with the member’s Primary Care Dentist
- Whether and how the primary care dentist is to refer members to specialists
- After-hours coverage
- Coordinate the services the DBP furnishes to the member with the services the member receives from any other managed care plan during ongoing care.

7.8. Access to Specialty Providers

7.8.1.

The Health Plan shall assure the availability of access to specialty providers, as appropriate, for all members. The Health Plan shall assure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.

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7.8.2.

The Health Plan shall establish and maintain a provider network of dentist specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum:

- The Health Plan has signed a contract with providers of the specialty types listed below who accept new members and are available on at least a referral basis; and
- The Health Plan is in compliance with access and availability requirements.

7.8.3.

The Health Plan shall assure, at a minimum, the availability of the following providers, as appropriate for both adults and pediatric members, on at least a referral basis:

- Endodontists
- Maxillofacial Surgeons
- Oral Surgeons
- Orthodontists
- Pedodontists
- Periodontists
- Prosthodontists
- Special Needs Pedodontists

The Health Plan must use specialist with pediatric expertise when the need for pediatric specialty care is significantly different from the need for a general dentist.

7.8.4.

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

7.8.5.

In accordance with 42 CFR 438.208(c)(4), for enrollees determined to need a course of treatment, the DBP must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's identified needs.

7.9. FQHC/RHC Clinic Services

7.9.1.

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

7.9.2.

If Health Plan is unable to contract with an FQHC or RHC within the geographic service area and primary care dentist time and distance travel standards (Section 7.3.1), the Health Plan is not required to reimburse that FQHC or RHC for out-of-network services if FQHC or RHC services within Time and Distance to Primary Care Standards are available in that area unless:

- The medically necessary services are required to treat an emergency medical condition; or
- FQHC/RHC services are not available through the Health Plan within DHH's established time and distance travel standards.

7.9.3.

The Health Plan may stipulate that reimbursement will be contingent upon receiving a clean claim and all the medical records information required to update the member's medical records.

7.9.4.

The Health Plan shall inform members of these rights in their member handbooks.

7.9.5.

The Health Plan shall not enter into alternative reimbursement arrangements with FQHCs or RHCs without prior approval from DHH.

7.10. Significant Traditional Providers

The Health Plan should make a good faith effort to include in its network, primary care dentists and specialist who are significant traditional providers (STPs) provided that the STP:

- Agrees to participate as an in-network provider and abide by the provisions of the provider contract; and
- Meets the credentialing requirements.

7.11. Provider Network Development Management Plan

7.11.1.

The Health Plan shall develop and maintain a provider Network Development and Management Plan which ensures that the provision of core benefits and services will occur [42 CFR §438.207(b)]. The Network Development and Management Plan shall be submitted to DHH within thirty (30) days from the date the Health Plan signs to contract with DHH for evaluation and approval, as well as when significant changes occur and annually thereafter. The Network Development and Management Plan shall include the Health Plan's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services included in the Contract. When designing the network of providers, the Health Plan shall consider the following (42 CFR §438.206):

- Anticipated maximum number of Medicaid members;
- Expected utilization of services, taking into consideration the characteristics and healthcare needs of the members in the Health Plan;
- The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core benefits and services;
- The numbers of Health Plan providers who are not accepting new Health Plan members; and
- The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid enrollees with disabilities.

7.11.2.

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

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

7.11.3.

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

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7.11.4.

The Health Plan shall provide GEO mapping and coding of all network providers for each provider type by the deadline specified in the Schedule of Events, to geographically demonstrate network capacity. The Health Plan shall provide updated GEO coding to DHH quarterly, or upon material change (as defined in the Glossary) or upon request.

7.11.5.

The Health Plan shall develop and implement Network Development and Management policies and policies detailing how the Health Plan will [42 CFR §438.214(a)]:

7.11.5.1.

Communicate and negotiate with the network regarding contractual and/or program changes and requirements;

7.11.5.2.

Monitor network compliance with policies and rules of DHH and the Health Plan, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;

7.11.5.3.

Evaluate the quality of services delivered by the network;

7.11.5.4.

Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;

7.11.5.5.

Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English; and

7.11.5.6.

Process expedited and temporary credentials. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling;

7.11.5.7.

Provide training for its providers and maintain records of such training;

7.11.5.8.

Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;

7.11.5.9.

Ensure that provider calls are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 calendar days of receipt (this does not include referrals from DHH). If not resolved in 30 days the Health Plan must document why the issue goes unresolved; however, the issue must be resolved within 90 calendar days.

7.11.5.10.

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

7.11.6.

An evaluation of the initial Network Provider Development and Management Plan, including evaluation of the success of proposed interventions and any needed revisions, shall be submitted to DHH at the end of the first year of operations and annually thereafter.

7.11.7.

Network Development and Management policies shall be subject to approval by Bayou Health and shall be monitored through operational audits.

7.12. Material Change to Provider Network

7.12.1.

The Health Plan shall provide written notice to DHH, no later than seven (7) business days of any network provider contract termination that materially impacts the Health Plan's provider network, whether terminated by the Health Plan or the provider, and such notice shall include the reason(s) for the proposed action. A material change is defined as one which affects, or can reasonably be foreseen to affect, the Health Plan's ability to meet the performance and network standards as described in the Contract, including but not limited to the following:

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

7.12.2.

The Health Plan shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in expanded services, payments, or eligibility of a new population.

7.12.3.

When the Health Plan has advance knowledge that a material change will occur, the Health Plan must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.

7.12.4.

The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them.

7.12.5.

If DHH does not respond within thirty (30) calendar days the request and the notice are deemed approved. A material change in the Health Plan's provider network requires thirty (30) calendar days advance written notice to affected members for emergency situations (including natural disasters such as hurricanes). DHH will expedite the approval process in emergency situations.

7.12.6.

The Health Plan shall notify Bayou Health within one (1) business day of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, a provider dies, the provider moves from the service area and fails to notify the Health Plan, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR 438.207(c)]. The notification shall include:

- Information about how the provider network change will affect the delivery of covered services, and
- The Health Plan's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.

7.13. Coordination with Other Service Providers

The Health Plan shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Bayou Health Prepaid Health Plans; Bayou Health Shared Savings Plans; Magellan; Head Start programs; Healthy Start programs; Nurse Family Partnership; Early

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Intervention programs; and school systems. Such cooperation may involve sharing of information (with the consent of the member).

7.14. Subcontract Requirements

7.14.1.

The Health Plan shall provide or assure the provision of all core benefits and services specified in Section 6. The Health Plan may provide these services directly or may enter into subcontracts with providers who will provide services to the members in exchange for payment by the Health Plan for services rendered. Provider contracts are required with all providers of services unless otherwise approved by DHH. Any plan to delegate responsibilities of the Health Plan to a major subcontractor shall be submitted to DHH for approval.

7.14.2.

In order to ensure that members have access to a broad range of dental healthcare providers, the Health Plan shall not have a contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another Health Plan or in which the Health Plan represents or agrees that it will not contract with another provider. The Health Plan shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.

7.14.3.

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

7.14.3.1.

The Health Plan shall follow the State's credentialing and re-credentialing policy.

7.14.3.2.

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

7.14.4.

All laboratory testing sites providing services under this Contract must have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.

7.14.5.

As required by 42 CFR §438.230, the Health Plan shall be responsible to oversee all subcontractors' performance and shall be held accountable for any function and responsibility that it delegates to any subcontractor, including, but not limited to:

7.14.6.

All provider subcontracts must fulfill the requirements of 42 CFR Part §438 that are appropriate to the service or activity delegated under the subcontract;

7.14.7.

DHH shall have the right to review and approve or disapprove any and all provider subcontracts entered into for the provision of any services under this RFP.

7.14.8.

The Health Plan must evaluate the prospective subcontractor's ability to perform the activities to be delegated;

7.14.9.

The Health Plan must have a written agreement between the Health Plan and the subcontractor that specifies the activities and reporting responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;

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7.14.10.

The Health Plan shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards; and

7.14.10.1.

The Health Plan shall identify deficiencies or areas for improvement, and take corrective action.

7.14.11.

The Health Plan shall submit all major subcontracts, excluding provider subcontracts, for the provision of any services under this RFP to DHH for prior review and approval. DHH shall have the right to review and approve or disapprove any and all provider subcontracts entered into for the provision of any services under this RFP.

7.14.12.

Notification of amendments or changes to any provider subcontract which materially affect this Contract, shall be provided to DHH prior to the execution of the amendment in accordance with Section 23.1.

7.14.13.

The Health Plan shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§ 1128 (42 U.S.C. 1320a-7) (2001, as amended) or 1156 (42 U.S.C. 1320 c-5) (2001, as amended) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. The Health Plan shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

7.14.14.

The Health Plan shall provide written notification to DHH of its intent to terminate any provider subcontract that may materially impact the Health Plan's provider network and/or operations, as soon as possible, but no later than seven (7) calendar days prior to the effective date of termination. In the event of termination of a provider subcontract for cause, the Health Plan shall provide immediate written notice to the provider.

7.14.15.

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

7.14.16.

The Health Plan shall make a good faith effort to give written notice of termination of a subcontract provider, within fifteen (15) calendar days after receipt of issuance of the termination notice, to each Health Plan member who received his or her primary care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(5).

7.14.17.

All subcontracts executed by the Health Plan pursuant to this section shall, at a minimum, include the terms and conditions listed in Section 23 of this RFP. No other terms or conditions agreed to by the Health Plan and its subcontractor shall negate or supersede the requirements in Section 23.

7.15. Provider-Member Communication Anti-Gag Clause

7.15.1.

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

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

7.15.2.

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

7.15.3.

The Health Plan shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to Provider Incentive Plans.

8. Utilization Management

8.1. General Requirements

8.1.1.

The Health Plan shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization. The Health Plan shall submit UM policies and procedures to DHH for written approval within thirty (30) calendar days from the date the Contract is signed by the Health Plan, but no later than prior to the Readiness Review, annually thereafter, and prior to any revisions.

8.1.2.

The UM Program policies and procedures shall meet all URAC standards or equivalent and include medical management criteria and practice guidelines that:

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

8.1.3.

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

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

8.1.4.

The Health Plan shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.

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8.1.5.

The Health Plan shall take steps to encourage adoption of the guidelines, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers are consistently in compliance, based on Health Plan measurement findings. The Health Plan should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance. If providers falls below 90% compliance the Health Plan maybe subject to administrative sanctions.

8.1.6.

The Health Plan must identify the source of the medical management criteria used for the review of service authorization requests, including but not limited to:

- The vendor must be identified if the criteria were purchased;
- The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state dental care provider association or society;
- The guideline source must be identified if the criteria are based on national best practice guidelines; and
- The individuals who will make medical necessity determinations must be identified if the criteria are based on the dental/medical training, qualifications, and experience of the Health Plan Dental Director or other qualified and trained professionals.

8.1.7.

UM Program medical management criteria and practice guidelines shall be disseminated to all affected providers, members and, potential members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.

8.1.8.

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

8.1.9.

The Health Plan shall have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the Health Plan may deny authorization of the requested service(s).

8.1.10.

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

8.1.11.

The Health Plan shall use DHH's medical necessity definition as defined in LAC 50:l.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations. The Health Plan shall make medical necessity determinations that are consistent with the State's definition.

8.1.12.

The Health Plan shall submit written policies and processes for DHH approval, within thirty (30) calendar days, but no later than prior to the Readiness Review, of the contract signed by the Health Plan, on how the core benefits and services the Health Plan provides ensure:

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

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8.1.13.

The Health Plan must identify the qualification of staff who will determine medical necessity.

8.1.14.

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

8.1.15.

The Health Plan shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

8.1.16.

The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.

8.1.17.

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

8.1.18.

The Health Plan shall provide a mechanism to reduce inappropriate and duplicative use of healthcare services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The Health Plan shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The Health Plan may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR 438.210.

8.1.19.

The Health Plan shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210.

8.1.20.

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

8.1.21.

In accordance with 42 CFR §456.111 and 456.211, the Health Plan Utilization Review plan must provide that each enrollee's record includes information needed for the UR committee to perform UR required under this section. This information must include, at least, the following:

- Identification of the enrollee;
- The name of the enrollee's dentist;
- Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;
- The plan of care required under 42 CFR 456.80 and 456.180;
- Initial and subsequent continued stay review dates described under 42 CFR 456.128, 456.133; 456.233 and 456.234;
- Date of operating room reservation, if applicable; and
- Justification of emergency admission, if applicable.

8.2. Utilization Management Committee

8.2.1.

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

8.2.2.

The UM Committee shall provide utilization review and monitoring of UM activities of both the Health Plan and its providers and is directed by the Health Plan Dental Director. The UM Committee shall convene no less than quarterly and shall submit a summary of the meeting minutes to DHH within five (5) business days of each meeting. UM Committee responsibilities include:

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

8.2.3.

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

8.2.4.

The Health Plan shall maintain a written strategy for conducting medical record reviews, reporting results, and the corrective action process. The strategy shall be provided within thirty (30) calendar days from the date the Contract is signed by the Health Plan, but no later than prior to the Readiness Review, and annually thereafter. The strategy shall include, at a minimum, the following:

- Designated staff to perform this duty;
- The method of case selection;
- The anticipated number of reviews by practice site;
- The tool the Health Plan shall use to review each site; and
- How the Health Plan shall link the information compiled during the review to other Health Plan functions (e.g. QI, credentialing, peer review, etc.)

8.2.5.

The Health Plan shall conduct reviews at all primary care dentist sites with fifty (50) or more linked members and practice sites which include both individual offices and large group facilities. The Health Plan shall review each site at least one (1) time during each three (3) year period.

8.2.6.

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

8.2.7.

The Health Plan shall report the results of all medical record reviews to DHH quarterly with an annual summary.

8.3. Utilization Management Reports

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

8.4. Service Authorization

8.4.1.

Service authorization includes, but is not limited to, prior authorization.

8.4.2.

The Health Plan UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR 438.210 and state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:

8.4.2.1.

Written policies and procedures for processing requests for initial and continuing authorizations of services, where a provider does not request a service in a timely manner or refuses a service;

8.4.2.2.

Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;

8.4.2.3.

Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a healthcare professional who has appropriate clinical expertise in treating the enrollee's condition or disease;

8.4.2.4.

Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures;

8.4.2.5.

The Health Plan's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and

8.4.2.6.

The Health Plan's service authorization system shall have capacity to electronically store and report all service authorization requests, decisions made by the Health Plan regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.

8.4.3.

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

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8.5. Timing of Service Authorization Decisions

8.5.1. Standard Service Authorization

8.5.1.1.

The Health Plan shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension is requested. The Health Plan shall maintain documentation system to report to DHH on a monthly basis all service authorizations provided in the format specified by DHH.

8.5.1.2.

An extension may be granted for an additional fourteen (14) calendar days if the member or the provider or authorized representative requests an extension or if the Health Plan justifies to DHH a need for additional information and the extension is in the member's best interest. In no instance shall any determination of standard service authorization be made later than (25) calendar days from receipt of the request.

8.5.2. Expedited Service Authorization

In the event a provider indicates, or the Health Plan determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Health Plan shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.

8.5.2.1. Post Authorization

The Health Plan may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the Health Plan justifies to DHH a need for additional information and how the extension is in the member's best interest.

8.5.2.1.1.

The Health Plan shall make retrospective review determinations within thirty (30) calendar days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.

8.5.2.1.2.

The Health Plan shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.

8.5.2.2. Timing of Notice

8.5.2.2.1. Notice of Action

8.5.2.2.1.1. Approval

- For service authorization approval for a non-emergency admission, procedure or service, the Health Plan shall notify the provider of as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.
- For service authorization approval for extended stay or additional services, the Health Plan shall notify the provider rendering the service, whether a healthcare professional or facility or both, and the member receiving the service within one (1) business day of the service authorization approval.

8.5.2.2.1.2. Adverse

- The Health Plan shall notify the member, in writing using language that is easily understood, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or

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any other action as defined in Section 12.16.1 of this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.10(c) and (d), 42 CFR §438.404(c), and 42 CFR §438.210(b)(c)(d) and Section 12 of this RFP for member written materials.

- The Health Plan shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested.

8.5.2.3. Informal Reconsideration

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

- In a case involving an initial determination, the Health Plan shall provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the dentist or clinical peer making the adverse determination.
- The informal reconsideration should occur within one (1) business day of the receipt of the request and should be conducted between the provider rendering the service and the Health Plan's dentist authorized to make adverse determinations or a clinical peer designated by the Dental Director if the dentist who made the adverse determination cannot be available within one (1) business day.
- The Informal Reconsideration will in no way extend the 30 day required timeframe for a Notice of Appeal Resolution.

8.5.2.4. Exceptions to Requirements

- The Health Plan shall not require service authorization for emergency services or post-stabilization services as described in this Section whether provided by an in-network or out-of-network provider.
- The Health Plan shall not require service authorization or referral for EPSDT dental screening services.
- The Health Plan shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the Health Plan, regardless of whether such services are provided by an in-network or out-of-network provider, however, the Health Plan may require prior authorization of services beyond thirty (30) calendar days.
- During transition, the Health Plan is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider.

8.6. Medical History Information

8.6.1.

The Health Plan is responsible for eliciting pertinent medical record information from the treating healthcare provider(s), as needed and/or as requested by DHH, for purposes of making medical necessity determinations.

8.6.2.

The Health Plan shall take appropriate action when a treating healthcare provider does not cooperate with providing complete medical history information within the requested timeframe.

8.6.3.

Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, shall not be entitled to payment for the provision of such item or service.

8.6.4.

Should a provider fail or refuse to respond to the Health Plan's request for medical record information, at the Health Plan's discretion or directive by DHH, the Health Plan shall, at a minimum, impose financial penalties against the provider as appropriate.

8.7. Primary Care Dentist Utilization and Quality Profiling

8.7.1.

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

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8.7.2.

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

8.7.3.

The Health Plan shall submit individual primary care dentist profile reports to DHH quarterly. Health Plan primary care dentist profiling activities shall include, but are not limited to, the following:

8.7.3.1.

Utilization of out-of-network providers – The Health Plan shall maintain a procedure to identify and evaluate member out-of-network provider referral utilization by its primary care dentist panel;

8.7.3.2.

Emergency department utilization – The Health Plan shall maintain a procedure to identify and evaluate member emergency department referral utilization by its primary care dentist panel;

8.7.3.3.

Hospital admits, lab services, medications, and radiology services – The Health Plan shall maintain a procedure to identify and evaluate member's utilization; and

8.7.3.4.

Individual primary care dentist clinical quality performance measures as indicated in Appendix F.

8.7.4.

The Health Plan shall submit profile reports quarterly with an Annual Summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will make every effort to notify the Health Plan of additional required reports whether profile report or other reports, no less than sixty (60) calendar days prior to due date of those reports. However, there may be occasions the Health Plan will be required to produce reports in a shorter timeframe.

9. Provider Payments

The Health Plan shall administer an effective, accurate and efficient claims processing function that adjudicates and settles provider claims for covered services that are filed within the time frames specified by this Section and in compliance with all applicable State and federal laws, rules and regulations.

9.1. Minimum Reimbursement to In-Network Providers

9.1.1.

The Health Plan shall provide reimbursement for defined core benefits and services provided by an in-network provider. The Health Plan rate of reimbursement shall be no less than the published Medicaid fee-for-service rate in effect on date of service, unless DHH has granted an exception for a provider- initiated alternative payment arrangement.

Note: For network providers who receive cost based reimbursement for Medicaid services, the published Medicaid fee-for-service rate shall be the rate that would be received in the fee-for-service Medicaid program. Hereafter in this Section, unless otherwise specified, the above reimbursement arrangement is referred to as the "Medicaid rate." DHH will post updates to the Medicaid fee schedule and payment rates via the www.lamedicaid.com

9.1.2.

The network provider may enter into alternative reimbursement arrangements with the Health Plan if the network provider initiates the request and it is approved in advance by DHH. The provider shall submit the Request for Alternative Health Plan Reimbursement Arrangement Form to the following address:

Madeline McAndrew
Bayou Health Director

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Louisiana Department of Health and Hospitals
628 North 4th Street, Baton Rouge, LA 70802
Telephone Number: (225) 342-7878
Facsimile Number: (225) 342-9243
Email: maddie.mcandrew@la.gov

9.2. FQHC/RHC Contracting and Reimbursement

9.2.1.

The Health Plan must offer to contract for dental services, if applicable, with all FQHCs and RHCs in its service area. If an agreement cannot be reached between the Health Plan and FQHC/RHC, the Health Plan shall inform DHH.

9.2.2.

The Health Plan may stipulate that reimbursement will be contingent upon receiving a clean claim.

9.2.3.

The Health Plan shall reimburse an FQHC/RHC the Prospective Payment System (PPS) rate or Alternative Payment Date in effect on the date of service for each encounter.

9.2.4.

The Health Plan shall inform members of these rights in their member handbooks.

9.3. Reimbursement to Out-of-Network Providers

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

9.4. Effective Date of Payment for New Members

The Health Plan shall not be responsible for payment for core benefits and services prior to the effective date of a member's Health Plan enrollment. For new Health Plan members, the effective date of enrollment in the Health Plan is the first day of the following month.

9.5. Claims Processing Requirements

9.5.1.

All provider claims that are clean and payable must be paid according to the following schedule.

9.5.1.1.

Ninety percent (90%) of all cleans claims must be paid within fifteen (15) business days of the date of receipt (the date the Health Plan receives the claim as indicated by the date stamp on the claim).

9.5.1.2.

Ninety-nine percent (99%) of all clean claims must be paid within thirty (30) calendar days of the date of receipt.

9.5.1.3.

The date of payment is the date of the check or other form of payment.

9.5.2.

At a minimum, the Health Plan shall run one (1) provider payment cycle per week, on the same day each week, as determined by the Health Plan. The Health Plan and its subcontractors may, but mutual agreement, establish an alternative payment schedule.

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9.5.3.

The Health Plan shall support an Automated Clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

9.5.4.

The Health Plan shall encourage that its providers, as an alternative to the filing of paper-based claims, submit and receive claims information through electronic data interchange (EDI 837), i.e. electronic claims. Electronic claims must be processed in adherence to information exchange and data management requirements specified in Section 16.1 of if this RFP. As part of this Electronic Claims Management (ECM) function, the Health Plan shall also provide on-line and phone-based capabilities to obtain claims processing status information.

9.5.5.

The Health Plan shall generate Explanation of Benefits (EOBs) and Remittance Advices (RAs) in accordance with DHH standards for formatting, content and timeliness.

9.5.6.

The Health Plan shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid or SCHIP programs for fraud, abuse or waste or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employs someone on this list. The Health Plan shall not pay any claim submitted by a provider that is on payment hold under the authority of DHH or its authorized agent(s).

9.5.7.

Not later than the fifteenth (15th) business day after the receipt of a provider claim that does not meet clean claim requirements, the Health Plan shall pend the claim and request in writing (notification via email, the Health Plan Website/Provider Portal or an interim Explanation of Benefits satisfies this requirement) all outstanding information such that the claim can be deemed clean. After receipt of the requested information from the provider, the Health Plan must process the claim within fifteen (15) business days of the date of receipt (the date the Health Plan receives the claim as indicated by the date stamp on the claim).

9.5.8.

Claims denied for additional information must be closed (paid or denied) by the thirtieth (30th) calendar day following the date the claim is denied if all requested information is not received prior to the expiration of the 30-day period. The Health Plan shall send providers written notice (notification via email, the Health Plan Website/Provider Portal or an Explanation of Benefits satisfies this requirement) for each claim that is denied, including the reason(s) for the denial and the date the Health Plan received the provider to adjudicate the claim.

9.5.9.

The Health Plan shall pay providers interest at 12% per annum, calculated daily for the full period in which the clean claim remains unadjudicated beyond the 30-day claims processing deadline. Interest owed the provider must be paid the same date that the claim is adjudicated.

9.5.10.

The Health Plan shall process all appealed claims to a paid or denied status within (30) business days of receipt of the appealed claim.

9.5.11.

The Health Plan shall finalize all claims, including appealed claims, within twenty-four (24) months of the date of service.

9.5.12.

The Health Plan must deny any claim not initially submitted to the Health Plan by the three hundred and sixty-fifth (365) calendar day from the date of service, unless the Health Plan or its vendors created the error. If a provider files erroneously with DHHs FI, but produces documentation verifying that the initial filing of the claim occurred within the three hundred and sixty-five (365) calendar day period, the Health Plan shall process the provider's claim without denying for failure to timely file.

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9.5.13.

The Health Plan shall inform all network providers about the information required to submit a clean claim at least thirty (30) calendar days prior to the Operational Start Date. The Health Plan shall make available to network providers claims coding and processing guidelines for the applicable provider type. The Health Plan shall notify providers ninety (90) calendar days before implementing changes to claims coding and processing guidelines.

9.5.14.

In addition to the specific Website requirements outlined above, the Health Plan's Website shall be functionally equivalent to the Website maintained by DHHs FI.

9.5.15.

For the purposes of Health Plan reporting on payments to providers, an adjustment to a paid claim shall not be counted as a claim and electronic claims shall be treated as identical to paper-based claims.

9.6. Inappropriate Payment Denials

If the Health Plan has a pattern of inappropriately denying or delaying provider payments for services, the Health Plan may be subject to suspension of new enrollments, sanctions, contract cancellation, or refusal to contract in a future time period. This applies not only to situations where DHH has ordered payment after appeal but to situations where no appeal has been made (i.e. DHH is knowledgeable about the documented abuse from other sources).

9.7. Payment for Emergency Services

9.7.1.

The Health Plan shall reimburse providers for emergency services rendered without a requirement for service authorization of any kind.

9.7.1.1.

The Health Plan's protocol for provision of emergency services must specify that emergency services will be covered when furnished by a provider with which the Health Plan does not have a subcontract or referral arrangement.

9.7.1.2.

The Health Plan may not limit what constitutes an emergency dental condition on the basis of diagnoses or symptoms Health Plan.

9.7.1.3.

The Health Plan shall not deny payment for treatment when a representative of the Health Plan instructs the member to seek emergency services.

9.7.1.4.

The Health Plan shall not deny payment for treatment obtained when a member had an emergency dental condition and the absence of immediate medical attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of emergency dental condition.

9.7.1.5.

The Health Plan may, however, enter into contracts with providers or facilities that require, as a condition of payment, the provider or facility to provide notification to the Health Plan within a minimum of ten (10) business days after members are present at the emergency room, assuming adequate provision is given for such notification. The policy for non-payment must be included in the Health Plan Provider Manual.

9.7.1.6.

The Health Plan shall be financially responsible for emergency dental services, including transportation, and shall not retroactively deny a claim for emergency services, including transportation, to an emergency provider because the condition, which appeared to be an Emergency Dental Condition under the prudent layperson standard, was subsequently determined to be non-emergency in nature.

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9.7.2.

Expenditures for emergency services as previously described must be factored into the capitation rate described in Section 5 of this RFP and the Health Plan will not be entitled to receive any additional payments.

9.8. Provider Incentive Plans

9.8.1.

Provider Incentive Plans (PIPs) must comply with requirements for physician incentive plans in 42 CFR 417.479, 422.208, 422.210, and 438.6(h). Specific payment cannot be made directly or indirectly under a Provider Incentive Plan to a dentist or dentist group as an inducement to reduce or limit medically necessary services furnished to an individual.

9.8.2.

The Health Plan shall submit any information regarding incentives as may be required by DHH (see Section 9.8.2.1). The Health Plan shall receive approval from DHH prior to implementation of the PIP.

9.8.2.1.

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

- Services that are furnished by a dentist/group that are covered by any incentive plan;
- Type of incentive arrangement, e.g. withhold, bonus, capitation;
- Percent of withhold or bonus (if applicable);
- Panel size, and if patients are pooled, the approved method used; and
- If the dentist/group is at substantial financial risk, the entity must report proof the dentist/group has adequate stop loss coverage, including amount and type of stop-loss.

The Health Plan shall conduct periodic surveys of current and former enrollees where substantial financial risk exists (as specified in 42 CFR 422.208(h)). A summary of the results must be provided to any beneficiary who requests it (as specified in 42 CFR 422.210(b)).

9.8.2.2.

The Health Plan shall provide information on its incentive plans to any Medicaid member upon request (this includes the right to adequate and timely information on the plan).

10. Provider Services

10.1. Provider Relations

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

10.1.1.

Be available Monday through Friday from 7 am to 5 pm Central Time to address non-emergency provider issues and on a 24/7 basis for non-routine prior authorization requests;

10.1.2.

Assure each Health Plan provider is provided all rights outlined the Provider's Bill of Rights (see Appendix J);

10.1.3.

Provide for arrangements to handle emergent provider issues on a 24/7 basis;

10.1.4.

Provide ongoing provider training, respond to provider inquiries and provide general assistance to providers regarding program operations and requirements; and

10.1.5.

Ensure regularly scheduled visits to provider sites, as well as ad hoc visits as circumstances dictate.

10.2. Provider Toll-free Telephone Line

10.2.1.

The Health Plan must operate a toll-free telephone line to respond to provider questions, comments and inquiries.

10.2.2.

The provider access component of the toll-free telephone line must be staffed between the hours of 7am-7pm Central Time Monday through Friday to respond to provider questions in all areas, including but not limited to prior authorization requests, provider appeals, provider processes, provider complaints, and regarding provider responsibilities. The provider access component must be staffed on a 24/7 basis for prior authorization requests.

10.2.3.

The Health Plan's call center system must have the capability to track provider call management metrics.

10.2.4.

After normal business hours, the provider service component of the toll-free telephone line must include the capability of providing information regarding normal business hours and instructions to verify enrollment for any Health Plan member with an emergency or urgent medical condition. This shall not be construed to mean that the provider must obtain verification before providing emergency/urgent care.

10.3. Provider Website

10.3.1.

The Health Plan shall have a provider website. The provider website may be developed on a page within the Health Plan's existing website (such as a portal) to meet these requirements.

10.3.2.

The Health Plan provider website shall include general and up-to-date information about the Health Plan as it relates to the Louisiana Medicaid FFS, Bayou Health Plans. This shall include, but is not limited to:

- Health Plan provider manual;
- Health Plan-relevant DHH bulletins;
- Limitations on provider marketing;
- Information on upcoming provider trainings;
- A copy of the provider training manual;
- Information on the provider grievance system;
- Information on obtaining prior authorization and referrals; and
- Information on how to contact the Health Plan Provider Relations.

10.3.3.

The Health Plan provider website is considered marketing material and, as such, must be reviewed and approved in writing within thirty (30) calendar days of the date the Health Plan signs the Contract.

10.3.4.

The Health Plan must notify DHH when the provider website is in place and when any approved changes are made.

10.3.5.

The Health Plan must remain compliant with HIPAA privacy and security requirements when providing any member eligibility or member identification information on the website.

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10.3.6.

The Health Plan website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern.

10.4. Provider Handbook

10.4.1.

The Health Plan shall develop and issue a provider handbook within thirty (30) calendar days of the date the Health Plan signs the Contract with DHH. The Health Plan may choose not to distribute the provider handbook via surface mail, provided it submits a written notification to all providers that explains how to obtain the provider handbook from the Health Plan's website. This notification shall also detail how the provider can request a hard copy from the Health Plan at no charge to the provider. All provider handbooks and bulletins shall be in compliance with state and federal laws. The provider handbook shall serve as a source of information regarding Health Plan covered services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all Health Plan requirements are met. At a minimum, the provider handbook shall include the following information:

10.4.1.1.

Description of the Health Plan;

10.4.1.2.

Core benefits and services the Health Plan must provide;

10.4.1.3.

Emergency service responsibilities;

10.4.1.4.

Policies and procedures that cover the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the Health Plan to file a provider complaint and which individual(s) has the authority to review a provider complaint;

10.4.1.5.

Information about the Health Plan's Grievance System, that the provider may file a grievance or appeal on behalf of the member with the member's written consent, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers and the member's right to request continuation of services while utilizing the grievance system;

10.4.1.6.

Medical necessity standards as defined by DHH and practice guidelines;

10.4.1.7.

Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;

10.4.1.8.

Primary care dentist responsibilities;

10.4.1.9.

Other provider responsibilities under the subcontract with the Health Plan;

10.4.1.10.

Prior authorization and referral procedures;

10.4.1.11.

Medical records standards;

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10.4.1.12.

Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims;

10.4.1.13.

Health Plan prompt pay requirements (see Section 9);

10.4.1.14.

Notice that provider complaints regarding claims payment shall be sent to the Health Plan;

10.4.1.15.

Quality performance requirements; and

10.4.1.16.

Provider rights and responsibilities.

10.4.2.

The Health Plan shall disseminate bulletins as needed to incorporate any changes to the provider handbook.

10.4.3.

The Health Plan shall make available to DHH for approval a provider handbook specific to the Louisiana DBP, no later than thirty (30) calendar days from the date the Health Plan signs the Contract with DHH, but no later than prior to the Readiness Review.

10.5. Provider Education and Training

10.5.1.

The Health Plan shall provide training to all providers and their staff regarding the requirements of the Contract, including limitations on provider marketing, and identification of special needs of members. The Health Plan shall conduct initial training within thirty (30) calendar days of placing a newly contracted provider, or provider group, on active status. The Health Plan shall also conduct ongoing training, as deemed necessary by the Health Plan or DHH, in order to ensure compliance with program standards and the Contract.

10.5.2.

The Health Plan shall submit a copy of the Provider Training Manual and training schedule to DHH for approval within thirty (30) calendar days of the date the Health Plan signs the Contract with DHH. Any changes to the manual shall be submitted to DHH at least thirty (30) calendar days prior to the scheduled change and dissemination of such change.

10.6. Provider Complaint System

10.6.1.

The Health Plan shall establish a Provider Complaint System for in-network and out-of-network providers to dispute the Health Plan's policies, procedures, or any aspect of the Health Plan's administrative functions. As part of the Provider Complaint system, the Health Plan shall:

10.6.1.1.

Have dedicated provider relations staff for providers to contact via telephone, electronic mail, surface mail, and in person, to ask questions, file a provider complaint and resolve problems;

10.6.1.2.

Identify a staff person specifically designated to receive and process provider complaints;

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10.6.1.3.

Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties and applying the Health Plan's written policies and procedures; and

10.6.1.4.

Ensure that Health Plan executives with the authority to require corrective action are involved in the provider complaint process as necessary.

10.6.2.

The Health Plan shall have and implement written policies and procedures which detail the operation of the Provider Complaint System. The Health Plan shall submit its Provider Complaint System policies and procedures to DHH for review and approval within thirty (30) Calendar Days of the date the Contract with DHH is signed, or not later than prior to the Readiness Review. The policies and procedures shall include, at a minimum:

10.6.2.1.

Allowing providers thirty (30) calendar days to file a written complaint and a description of how providers file complaint with the Health Plan and the resolution time;

10.6.2.2.

A description of how and under what circumstances providers are advised that they may file a complaint with the Health Plan for issues that are Health Plan Provider Complaints and under what circumstances a provider may file a complaint directly to DHH/MMIS for those decisions that are not a unique function of the Health Plan;

10.6.2.3.

A description of how provider relations staff are trained to distinguish between a provider complaint and an member grievance or appeal in which the provider is acting on the member's behalf with the member's written consent;

10.6.2.4.

A process to allow providers to consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint; and

10.6.2.5.

A process for thoroughly investigating each complaint using applicable sub-contractual provisions, and for collecting pertinent facts from all parties during the investigation.

10.6.2.6.

A description of the methods used to ensure that Health Plan executive staff with the authority to require corrective action are involved in the complaint process, as necessary;

10.6.2.7.

A process for giving providers (or their representatives) the opportunity to present their cases in person;

10.6.2.8.

Identification of specific individuals who have authority to administer the provider complaint process;

10.6.2.9.

A system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing; and

10.6.2.10.

A provision requiring the Health Plan to report the status of all provider complaints and their resolution to DHH on a monthly basis in the format required by DHH.

10.6.3.

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

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

11. Enrollment and Disenrollment

11.1. Enrollment

11.1.1.

The Medicaid Fiscal Intermediary (FI) shall provide Louisiana Medicaid recipient information to the Health Plan via an electronic file transfer, hereafter referred to as the "Member File". The Health Plan will utilize the Member File to identify all individuals eligible for enrollment, based on predetermined eligibility criteria as outlined in Section 3_of this RFP. The Health Plan's responsibilities subsequent to eligibility determination will include, but will not necessarily be limited to, the following:

11.1.2.

Health Plan staff shall be available by telephone as appropriate to provide assistance to DBP potential members, and educating the Medicaid eligible about the DBP in general, including the manner in which services typically are accessed under the Health Plan, the role of the primary care dentist, the responsibilities of the Health Plan member, his/her right to file grievances and appeals, and the rights of the member to choose any primary care dentist within the Health Plan, subject to the capacity of the provider.

11.1.2.1.

Educating the member, or in the case of a minor, the member's parent or guardian, about benefits and services available through the DBP.

11.1.2.2.

Identifying any barriers to access to care for the Health Plan members such as:

- Necessity for multi-lingual interpreter services, and
- Special assistance needed for members with visual and hearing impairment and members with physical or mental disabilities.

11.2. Enrollment Procedures

11.2.1. Acceptance of All Eligibles

The Health Plan shall not discriminate against DBP members on the basis of their health history, health status, need for healthcare services or adverse change in health status; or on the basis of age, religious belief, sex/gender, or sexual orientation. This applies to enrollment, re-enrollment or disenrollment from the Health Plan. The Health Plan shall be subject to monetary penalties and other administrative sanctions if it is determined by DHH that the Health Plan has requested disenrollment for any of these reasons.

11.2.2. Effective Date of Enrollment

Health Plan enrollment for members received on or before the second to last working day of a given month will be effective at 12:01AM on the first (1st) calendar day of the month following assignment. Health Plan enrollment for members received after the second to last working day in a given month, will be effective at 12:01AM on the first (1st) calendar day of the second (2nd) month following assignment.

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11.2.3. Change in Status

The Health Plan agrees to report in writing to DHH's Medicaid Customer Service Unit any changes in contact information or living arrangements for families or individual members within five (5) business days of identification, including changes in mailing address, residential address if outside Louisiana, email address, telephone number and insurance coverage.

11.2.4. Assignment of Primary Care Dentists

11.2.4.1.

The Health Plan shall encourage the continuation of any existing satisfactory provider/patient relationship with current primary care dentists participating in the Health Plan.

11.2.4.2.

The Health Plan shall contact the member, as part of the welcome process, within ten (10) business days of receiving the Member File from the FI to assist the member in making a selection of a primary care dentist. The Health Plan shall confirm the primary care dentist selection information in a written notice to the member. If no primary care dentist is selected by the member, the Health Plan shall:

11.2.4.3.

Inform the member that each family member has the right to choose his/her own primary care dentist. The Health Plan may explain the advantages of selecting the same primary care dentist for all family members, as appropriate.

11.2.4.4.

Members, for whom the Health Plan is the primary payor, who do not proactively choose a primary care dentist Health Plan will be auto-assigned to a primary care dentist by the Health Plan. Members, for whom the Health Plan is the secondary payor, will not be assigned to a primary care dentist by the Health Plan, unless the members request that the Health Plan do so.

11.2.4.5.

The Health Plan shall have written policies and procedures for handling the assignment of its members to a primary care dentist. The Health Plan is responsible for linking to a primary care dentist all assigned Health Plan members for whom the Health Plan is the primary payor.

11.3. Primary Care Dentist Auto-Assignments

11.3.1.

The Health Plan is responsible for developing a primary care dentist automatic assignment methodology in collaboration with DHH to assign a member for whom the Health Plan is the primary payor to a primary care dentist when the member:

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

11.3.2.

Assignment shall be made to a primary care dentist with whom, based on fee for service claims history or prior linkage, the member has a historical provider relationship. If there is no historical primary care dentist relationship, the member may be auto-assigned to a provider who is the assigned primary care dentist for an immediate family member enrolled in the Health Plan. If other immediate family members do not have an assigned primary care dentist, auto-assignment shall be made to a provider with whom a family member has a historical provider relationship.

11.3.3.

If there is no member or immediate family historical usage, members shall be auto-assigned to a primary care dentist using an algorithm developed by the proposer, based on the age and sex of the member and geographic proximity.

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11.3.4.

The final primary care dentist automatic assignment methodology must be provided thirty (30) days from the date the Health Plan signs the contract with DHH, but no later than prior to the Readiness Review. Approval must be obtained from the Department prior to implementation. This methodology must be made available via the Health Plan's website, Provider Handbook, and Member Handbook.

11.3.5.

The Health Plan shall be responsible for providing to DHH, information on the number of Medicaid member linkages and remaining capacity of each individual primary care dentist of additional Medicaid member linkages on a quarterly basis.

11.3.6.

If the member does not select a primary care dentist and is auto assigned to a primary care dentist by the Health Plan, the Health Plan shall allow the member to change primary care dentist.

11.3.7.

If a member requests to change his or her primary care dentist, at any time, the Health Plan may agree to grant this request for good cause.

11.3.8.

The Health Plan shall have written policies and procedures for allowing members to select a new primary care dentist, including auto-assignment, and provide information on options for selecting a new primary care dentist when it has been determined that a primary care dentist is non-compliant with provider standards (i.e. quality of care) and is terminated from the Health Plan, or when a primary care dentist change is ordered as part of the resolution to a grievance proceeding, The Health Plan shall allow members to select another primary care dentist within ten (10) business days of the postmark date of the termination of primary care dentist notice to members and provide information on options for selecting a new primary care dentist.

11.3.9.

The Health Plan shall have policies for accessing emergency/urgent care during this transition period. These policies and procedures shall be submitted within thirty (30) calendar days from the date the Health Plan signs the Contract with DHH, but no later than prior to Readiness Review.

11.4. Disenrollment

Disenrollment is any action taken by DHH or its designee to remove a Health Plan member from the Health Plan following the receipt and approval of a written request for disenrollment or a determination made by DHH or its designee that the member is no longer eligible for Medicaid or the DBP. The Health Plan shall submit to DHH a Quarterly Disenrollment Report which summarizes all disenrollments for its members in the format specified by DHH.

DHH will notify the Health Plan of the member's disenrollment due to the following reasons:

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

11.4.1. Disenrollment Effective Date

11.4.1.1.

The effective date of disenrollment shall be no later than the first day of the second month following the calendar month the request for disenrollment is filed.

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11.4.1.2.

If DHH or its designee fails to make a disenrollment determination by the first day of the second month following the month in which the request for disenrollment is filed, the disenrollment is considered approved. The Health Plan shall process all member file updates from the FI prior to the reconciliation process. Noncompliance with the reconciliation process may result in administrative sanctions.

11.4.1.2.1.

DHH and the Health Plan shall reconcile enrollment/disenrollment issues at the end of each month utilizing an agreed upon procedure.

11.5. Enrollment and Disenrollment Updates

11.5.1. Daily Updates

The FI shall make available to the Health Plan daily incremental Member File updates in the format specified in the Systems Companion Guide. The Health Plan shall have written policies and procedures for receiving these updates, incorporating them into its management information system and ensuring this information is available to their providers. Policies and procedures shall be available for review at the Readiness Review.

DHH will use its best efforts to ensure that the Health Plan receives timely and accurate information to determine Health Plan membership. In the event of discrepancies or irresolvable differences between DHH and the Health Plan regarding members eligible for enrollment, DHH's decision is final.

11.5.2. Weekly Reconciliation

11.5.2.1. Enrollment

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

11.5.2.2. Payment

The Health Plan will receive monthly electronic file (ASC X12N 820 Transaction) from the FI listing all members for whom the Health Plan received a capitation payment and the amount received. The Health Plan is responsible for reconciling this listing against its internal records. It is the Health Plan's responsibility to notify the FI of any discrepancies. Lack of compliance with reconciliation requirements will result in the withholding of portion of future monthly payments and/or monetary penalties as defined Section 20 of this RFP until requirements are met.

12. Marketing and Member Education

12.1. General Guidelines

12.1.1.

Marketing, for purposes of this RFP, is defined in 42 CFR §438.104 (a) as any communication from the Health Plan to a Medicaid eligible who is not enrolled in the Health Plan.

12.1.2.

Marketing differs from member education, which is defined as communication with an enrolled member of the Health Plan for the purpose of retaining the member as a member of the Health Plan, and improving the health status of enrolled members.

12.1.3.

Marketing and member education include both verbal presentations and written materials.

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12.1.4.

Marketing materials generally include, but are not limited to, the concepts of advertising, public service announcements, printed publications, broadcasts and electronic messages designed to increase awareness and interest in the Health Plan. This includes any information that references the Health Plan, is intended for general distribution and is produced in a variety of print, broadcast or direct marketing mediums.

12.1.5.

Member education materials generally include, but are not limited to, member handbooks, identification cards, provider directories, health education materials, form letters, mass mailings, emails and member letters and newsletters.

12.1.6.

All marketing and member education guidelines are applicable to the Health Plan, its agents, subcontractors, volunteers and/or providers.

12.1.7.

All marketing and member education activities shall be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of beneficiaries or the general community.

12.1.8.

All marketing and member education materials and activities shall comply with the requirements in 42 CFR §438.10 and the DHH requirements set forth in this RFP and the Dental Benefit Program Companion Guide. In accordance with 42 CFR §438.10(b)(1), DHH shall provide the Health Plan on its website the prevalent non-English language spoken by enrollees by parish. The Health Plan, as required in 42 CFR §438.10(c)(3), shall be responsible for providing to enrollees and potential enrollees written information in the prevalent non-English language in the Health Plan's particular service area. In accordance with 42 CFR §438.10(c)(4)-(5) the Health Plan shall provide enrollees oral interpretation services available free of charge, to all non-English languages rather than to only those DHH identifies as prevalent. The Health Plan is responsible for providing all written materials in alternative formats and in a manner that considers the special needs of those who, for example, are visually limited or have limited reading proficiency.

12.1.9.

The Health Plan is responsible for creation, production and distribution of its own marketing and member education materials to its members.

12.1.10.

Under the DBP, all **direct** marketing to members or potential members must be reviewed and approved in writing by DHH or its designee in accordance with Social Security Act § 1932 (d)(2)(A) and 42 CFR §438.104.

12.1.11.

The Health Plan shall assure DHH that marketing and member education materials are accurate and do not mislead, confuse, or defraud the member/potential member or DHH as specified in Social Security Act § 1932 (d) and 42 CFR §438.104.

12.1.12.

The Health Plan shall participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members and comply with the Office of Minority Health, Department of Health and Human Services' "Cultural and Linguistically Appropriate Services Guidelines" at the following URL:

<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15> and participate in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees.

12.2. Marketing and Member Education Plan

12.2.1.

The Health Plan shall develop and implement a plan detailing the marketing and member education activities it will undertake and materials it will create during the contract period, incorporating DHH's requirements for participation in the

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DBP. The detailed plan must be submitted to DHH for review and approval within thirty (30) calendar days from the date the Contract is signed, but no later than prior to the Readiness Review.

12.2.2.

The Health Plan shall not begin member education activities prior to the approval of the marketing and member education plan.

12.2.3.

The Health Plan's plan shall take into consideration projected enrollment levels for equitable coverage of the entire state. The plan should clearly distinguish between marketing activities and materials and member education activities and materials. The plan shall include, but is not limited to:

12.2.3.1.

Stated marketing and member education goals and strategies;

12.2.3.2.

A marketing and member education calendar, which begins with the date of the signed contract by the Health Plan, but no later than prior to the Readiness Review, between DHH and the Health Plan, and runs through the first calendar year of providing services to Medicaid enrollees, that addresses all marketing areas: advertising plans, coverage areas, Website development and launch plans, printed materials, material distribution plans (including specific locations), outreach activities (health fairs, area events, etc.);

12.2.3.3.

Distribution methods and schedules for all materials, including media schedules for electronic or print advertising (include date and station or publication);

12.2.3.4.

The Health Plan's plans for new member outreach, including welcome packets and welcome call;

12.2.3.5.

How the Health Plan plans to meet the informational needs, relative to marketing (for prospective members) and member education (for current members), for the physical and cultural diversity of Louisiana. This may include, but is not limited to a description of provisions for non-English speaking prospective members, interpreter services, alternate communication mechanisms (such as sign language, Braille, audio tapes);

12.2.3.6.

A list of all subcontractors engaged in marketing or member education activities for the Health Plan;

12.2.3.7.

A copy of the Health Plan training curriculum for marketing representatives (both internal and subcontractor);

12.2.3.8.

The Health Plan's plans to monitor and enforce compliance with all marketing and member education guidelines, in particular the monitoring of prohibited marketing methods, among internal staff and subcontractors;

12.2.3.9.

Copies of all marketing and member education materials (print and multimedia) the Health Plan or any of its subcontractor's plans to distribute that are directed at Medicaid eligibles or potential eligible;

12.2.3.10.

Copies of marketing and member education materials that are 1) currently in concept form, but not yet produced (should include a detailed description) or 2) samples from other states that will be duplicated in a similar manner for the DBP population;

12.2.3.11.

Details of proposed marketing and member education activities and events;

12.2.3.12.

Details regarding the basis it uses for awarding bonuses or increasing the salary of marketing representatives and employees involved in marketing;

12.2.3.13.

Details for supplying current materials to service regions as well as plans to remove outdated materials in public areas; and

12.2.3.14.

Any changes to the marketing and member education plan or included materials or activities must be submitted to DHH for approval at least thirty (30) days before implementation of the marketing or member education activity, unless the Health Plan can demonstrate just cause for an abbreviated timeframe.

12.3. Marketing and Member Education Materials Approval Process

12.3.1.

The Health Plan must obtain prior written approval from DHH for all marketing and member education materials for potential or current members as outlined in the Dental Benefit Program Companion Guide. This includes, but is not limited to, print, television and radio advertisements; member handbooks, identification cards and provider directories; Health Plan website screen shots; promotional items; brochures; letters and mass mailings and emailings. Neither the Health Plan nor its subcontractors may distribute any Health Plan marketing or member education materials without DHH consent.

12.3.2.

All proposed materials must be submitted to DHH using the Marketing and Member Education Materials Approval Form. (See Appendix M) Materials must be submitted in PDF format unless an alternative format is approved or requested by DHH.

12.4. Member Education – Required Materials and Services

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

12.4.1. New Member Orientation

12.4.1.1.

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

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

12.4.1.2.

The Health Plan shall identify and educate members who access the system inappropriately and provide continuing education as needed.

12.4.1.3.

The Health Plan may propose, for approval by DHH, alternative methods for orienting new members and must be prepared to demonstrate their efficacy.

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12.4.1.4.

The Health Plan shall have written policies and procedures for notifying newly identified members within ten (10) business days after receiving the Member File from the FI. This notification must be in writing and include a listing of primary care dentist names (and include locations, and office telephone numbers) that the member may choose as their primary dental care provider.

12.4.1.5.

The Health Plan shall submit a copy of the procedures to be used to contact Health Plan members for initial member education to DHH for approval within thirty (30) days following the date the Contract is signed by the Health Plan, but no later than prior to the Readiness Review. These procedures shall adhere to the process and procedures outlined in Section 11 and 12 of this RFP, the Dental Benefit Program Companion Guide and the Contract.

12.4.1.6.

New Medicaid eligibles who have not proactively selected a primary care dentist or whose choice of primary care dentist is not available will have the opportunity to select a primary care dentist within the Health Plan that: 1) is a Louisiana Medicaid Program enrolled provider; 2) has entered into a subcontract with the Health Plan; and 3) is within a reasonable commuting distance from their residence.

12.4.2. Communication with New Members

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

12.4.3. Welcome Packets

- The Health Plan shall send a welcome packet to new members within ten (10) business days from the date of receipt of the Member File from the FI. During the transition of the DBP Program from the FFS Program, the Health Plan may have up to twenty-one (21) days to provide welcome packets.
- The Health Plan must mail a welcome packet to each new member. When the name of the responsible party for the new member is associated with two (2) or more new members, the Health Plan is only required to send one welcome packet.
- All contents of the welcome packet are considered member education materials and, as such, shall be reviewed and approved in writing by DHH prior to distribution according to the provisions described in this RFP and the Dental Benefit Program Companion Guide. Contents of the welcome packets shall include those items specified in the Contract. The welcome packet shall include, but is not limited to:
 - A welcome letter highlighting major program features and contact information for the Health Plan;
 - A Member Handbook;
 - The Health Plan Member ID Card (if mailed under a separate mailing; and
 - A Provider Directory when specifically requested by the member (also must be available in searchable format on-line).

12.4.3.1.

The Health Plan shall adhere to the requirements for the Member Handbook, and Provider Directory as specified in this RFP, the Dental Benefit Program Companion Guide, its attachments, and in accordance with 42 CFR §438.10 (f)(6).

12.4.3.2.

The Health Plan shall agree to make available the full scope of core benefits and services to which a member is entitled immediately upon his or her effective date of enrollment, which, will always be the 1st day of a month. During the transition to the DBP from the FFS Program, the Health Plan may have up to twenty-one (21) days to make welcome calls.

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12.4.4. Welcome Calls

- The Health Plan shall make welcome calls to newly identified members within fourteen (14) business days of receipt of the Member File from the FI.
- The Health Plan shall review the primary care dentist's assignment if an automatic assignment was made and assist the member in changing the primary care dentist if requested by the member.
- The Health Plan shall develop and submit to DHH for approval a script to be used during the welcome call to discuss the following information with the member:
 - A brief explanation of the program;
 - Statement of confidentiality;
 - The availability of oral interpretation and written translation services and how to obtain them free of charge;
 - The importance of the member's use of preventive dental care before the member requires care due to an illness or condition;
 - Pro-active selection of the member's primary care dentist; and
 - A discussion to discover whether the member is pregnant has a chronic condition, or any special healthcare needs. Assistance in making an appointment shall be offered to all members with such issues.

12.5. Health Plan Member Handbook

12.5.1.

The Health Plan shall develop and maintain a member handbook that adheres to the requirements in 42 CFR §438.10 (f)(6).

12.5.2.

At a minimum, the member handbook shall include the following information:

12.5.2.1.

Table of contents;

12.5.2.2.

A general description about how the Health Plan operates, member rights and responsibilities, appropriate utilization of services including Emergency Room for non-emergent conditions, and a description of the primary care dentist selection process;;

12.5.2.3.

Member's right to change providers within the Health Plan;

12.5.2.4.

Any restrictions on the member's freedom of choice among Health Plan providers;

12.5.2.5.

Member's rights and protections, as specified in 42 CFR §438.100 and this RFP;

12.5.2.6.

The amount, duration, and scope of benefits available to the member under the contract between the Health Plan and DHH in sufficient detail to ensure that members understand the benefits to which they are entitled and information about health education and promotion programs;

12.5.2.7.

Procedures for obtaining benefits, including prior authorization requirements;

12.5.2.8.

The extent to which, and how, members may obtain benefits, from out-of-network providers;

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12.5.2.9.

The extent to which, and how, after-hours and emergency coverage are provided, including:

- What constitutes an emergency dental condition, and emergency services as defined in 42 CFR 438.114(a);
- That prior authorization is not required for emergency services;
- The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent. The mechanism, incorporated in the member grievance procedures, by which a member may submit, whether oral or in writing, a service authorization request for the provision of services;
- The locations of any emergency settings and other locations at which providers furnish emergency services covered by the Health Plan; and
- That, subject to the provisions of 42 CFR §438, the member has a right to use any hospital or other setting for emergency care.

12.5.2.10.

Policy on referrals for specialty care, for other benefits not furnished by the member's primary care dentist;

12.5.2.11.

That the member has the right to refuse to undergo any medical service, diagnoses, or treatment or to accept any health service provided by the Health Plan if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds;

12.5.2.12.

For counseling or referral services that the Health Plan does not cover because of moral or religious objections, the Health Plan is required to furnish information on how or where to obtain the service;

12.5.2.13.

Member grievance, appeal and state fair hearing procedures and time frames, as described in 42 CFR §438.400 through §438.424;

12.5.2.14.

Member grievance, appeal and fair hearing procedures that include the following:

- For State Fair Hearing:
 - The right to a hearing;
 - The method for obtaining a hearing; and
 - The rules that govern representation at the hearing.
- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The toll-free numbers that the member can use to file a grievance or an appeal by phone;
- The fact that, when requested by the member:
 - Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and
 - The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.
- In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of the DHH who has final authority to determine whether services must be provided.

12.5.2.15.

Information to call the Medicaid Customer Service Unit toll free hotline or visit a local Medicaid eligibility office to report if family size, living arrangements, parish of residence, or mailing address changes;

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12.5.2.16.

How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a “no show”;

12.5.2.17.

A description of Member Services and the toll-free number, fax number, email address and mailing address to contact Member Services;

12.5.2.18.

How to obtain emergency and non-emergency medical transportation;

12.5.2.19.

Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services as they relate to dental benefits and services provided by the Health Plan;

12.5.2.20.

Reporting requirements for the member that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported the Health Plan and Medicaid;

12.5.2.21.

Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Health Plan or DHH;

12.5.2.22.

Instructions on how to request multi-lingual interpretation and translation when needed at no cost to the member. This instruction shall be included in all versions of the handbook in English, Spanish and Vietnamese;

12.5.2.23.

Information on the member’s right to a second opinion at no cost and how to obtain it;

12.5.2.24.

Any additional text provided to the Health Plan by DHH or deemed essential by the Health Plan;

12.5.2.25.

The date of the last revision;

12.5.2.26.

Additional information that is available upon request, including the following:

- Information on the structure and operation of the Health Plan;
- Provider Incentive Plans [42 CFR §438.6(h)].

12.6. Member Identification (ID) Cards

Health Plan members shall use their DHH issued Medicaid ID card to access benefits and services covered as part of the Dental Benefit Program. The Dental Benefit Program Health Plan will not provide members with a separate ID card.

12.6.1.

The DHH issued Medicaid ID card shall not be proof of eligibility, but can be used for accessing the state's electronic eligibility verification systems by Health Plan providers. These systems will contain the most current information available to DHH, including specific information regarding Health Plan enrollment.

12.7. Provider Directory for Members

12.7.1.

The Health Plan shall develop and maintain a Provider Directory in two (2) formats:

- Web-based, searchable, online directory for members and the public; and
- A hard copy directory for members upon request only;

12.7.2.

DHH or its designee shall provide the file layout for the electronic directory to the Health Plan after approval of the Contract. The Health Plan shall submit templates of its provider directory to DHH within thirty (30) days from the date the Contract is signed, but no later than prior to Readiness Review.

12.7.3.

The hard copy directory for members shall be reprinted with updates at least annually. Inserts may be used to update the hard copy directories monthly for new members and to fulfill only requests. The web-based online version shall be updated in real time, however no less than weekly. The electronic version shall be updated prior to each submission to DHH's Fiscal Intermediary. While daily updates are preferred, the Health Plan shall at a minimum submit no less than weekly.

12.7.4.

In accordance with 42 CFR §438.10(f) (6), the provider directory shall include, but not be limited to:

12.7.4.1.

Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Medicaid enrollee's service area, including identification of providers, primary care dentists, specialists, and hospitals at a minimum, that are not accepting new patients;

12.7.4.2.

Identification of primary care dentists, specialists, and hospitals primary care dentist groups, clinic settings, FQHCs and RHCs in the service area;

12.7.4.3.

Identification of any restrictions on the enrollee's freedom choice among network providers; and

12.7.4.4.

Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours).

12.8. Member Call Center

12.8.1.

The Health Plan shall maintain a toll-free member service call center, physically located in the United States, with dedicated staff to respond to member questions including, but not limited to, such topics as:

- Explanation of Health Plan policies and procedures;
- Prior authorizations;
- Access information;
- Information on primary care dentists or specialists;
- Referrals to participating specialists;
- Resolution of service and/or medical delivery problems; and
- Member grievances.

12.8.2.

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

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12.8.3.

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

12.8.4.

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

12.8.5.

The Health Plan must develop a contingency plan for hiring call center staff to address overflow calls and emails and to maintain call center access standards set forth for Health Plan performance. The Health Plan must develop and implement a plan to sustain call center performance levels in situations where there is high call/email volume or low staff availability. Such situations may include, but are not limited to, increases in call volume, emergency situations (including natural disasters such as hurricanes), staff in training, staff illnesses and vacations.

12.8.6.

The Health Plan must develop telephone help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards. The Health Plan shall submit these telephone help line policies and procedures, including performance standards, to DHH for written approval prior to implementation of any policies. This must include a capability to track and report information on each call. The Health Plan call center must have the capability to produce an electronic record to document a synopsis of all calls. The tracking shall include sufficient information to meet the reporting requirements.

12.8.7.

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

12.9. ACD System

12.9.1.

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

12.9.1.1.

Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;

12.9.1.2.

Transfer calls to other telephone lines;

12.9.1.3.

Provide an option to speak to a live person (during call center hours of operation);

12.9.1.4.

Provide detailed analysis as required for the reporting requirements, as specified, including the quantity, length and types of calls received, elapsed time before the calls are answered, the number of calls transferred or referred; abandonment rate; wait time; busy rate; response time; and call volume;

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12.9.1.5.

Provide a message that notifies callers that the call may be monitored for quality control purposes;

12.9.1.6.

Measure the number of calls in the queue at peak times;

12.9.1.7.

Measure the length of time callers are on hold;

12.9.1.8.

Measure the total number of calls and average calls handled per day/week/month;

12.9.1.9.

Measure the average hours of use per day;

12.9.1.10.

Assess the busiest times and days by number of calls;

12.9.1.11.

Record calls to assess whether answered accurately;

12.9.1.12.

Provide a backup telephone system that shall operate in the event of line trouble, emergency situations including natural disasters, or other problems so that access to the telephone lines is not disrupted;

12.9.1.13.

Provide interactive voice response (IVR) options that are user-friendly to members and include a decision tree illustrating IVR system; and

12.9.1.14.

Inform the member to dial 911 if there is an emergency.

12.9.2. Call Center Performance Standards

12.9.2.1.

Answer ninety-five (90) percent of calls within thirty (30) seconds by a live person or direct the call to an automatic call pickup system with IVR options;

12.9.2.2.

No more than one percent (1%) of incoming calls receives a busy signal;

12.9.2.3.

Maintain an average hold time (the time a caller spends waiting to speak to a live person, once requested) of three (3) minutes or less; Hold time, or wait time, for the purposes of this RFP includes 1) the time a caller spends waiting for a customer service representative to assist them after the caller has navigated the IVR system and requested a live person, and 2) the measure of time when a customer service representative places a caller on hold.

12.9.2.4.

Maintain abandoned rate of calls of not more than five (5) percent.

12.9.2.5.

The Health Plan must conduct ongoing quality assurance to ensure these standards are met.

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12.9.2.6.

If DHH determines that it is necessary to conduct onsite monitoring of the Health Plan's member call center functions, the Health Plan is responsible for all reasonable costs incurred by DHH or its authorized agent(s) relating to such monitoring.

12.9.2.7.

The Health Plan shall have written policies regarding member rights and responsibilities. The Health Plan shall comply with all applicable state and federal laws pertaining to member rights and privacy. The Health Plan shall further ensure that the Health Plan's employees, contractors and Health Plan providers consider and respect those rights when providing services to members.

12.9.3. Members Rights

The rights afforded to current members are detailed in Appendix Q, Members' Bill of Rights.

12.9.4. Member Responsibilities

12.9.4.1.

The Health Plan shall encourage each member to be responsible for his own healthcare by becoming an informed and active participant in their care. Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their healthcare provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.

12.9.4.2.

The Health Plan members' responsibilities shall include but are not limited to:

- Presenting their DHH issued Medicaid ID card when using healthcare services;
- Being familiar with the Health Plan procedures to the best of the member's abilities;
- Calling or contacting the Health Plan to obtain information and have questions answered;
- Providing participating network providers with accurate and complete medical information;
- Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible;
- Living healthy lifestyles and avoiding behaviors know to be detrimental to their health;
- Following the grievance process established by the Health Plan if they have a disagreement with a provider; and
- Making every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.

12.10. Notice to Members of Provider Termination

12.10.1.

The Health Plan shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.

12.10.2.

The Health Plan shall provide notice to a member, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within ten (10) calendar days from the date the Health Plan becomes aware of such, if it is prior to the change occurring.

12.10.3.

Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the Health Plan, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice

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shall be issued immediately upon the Health Plan becoming aware of the circumstances. The Health Plan shall document the date and method of notification of termination.

12.11. Additional Member Educational Materials and Programs

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

12.12. Oral and Written Interpretation Services

12.12.1.

The Health Plan must make real-time oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages not just those that Louisiana specifically requires (Spanish and Vietnamese). The member is not to be charged for interpretation services. The Health Plan must notify its members that oral interpretation is available for any language and written information is available in Spanish and Vietnamese and how to access those services. On materials where this information is provided, the notation should be written in both Spanish and Vietnamese.

12.12.2.

The Health Plan shall ensure that translation services are provided for written marketing and member education materials for any language that is spoken as a primary language for 200 or more members of the Health Plan within a GSA. Within 90 calendar days of notice from DHH, materials must be translated and made available. Materials must be made available at no charge in that specific language to assure a reasonable chance for all members to understand how to access the Health Plan and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).

12.13. Marketing Reporting and Monitoring

12.13.1. Reporting to DHH

12.13.1.1.

The Health Plan must provide a monthly report in a format prescribed by DHH in the Dental Benefit Program Companion Guide to demonstrate the progression of the marketing and member education plan. The monthly report must be provided by the 10th day of the following month and include a listing of all completed marketing activities and distributed marketing materials.

12.13.1.2.

A summary report of all marketing and member education efforts must be submitted to DHH within thirty (30) days of the end of the calendar year.

12.13.2. Reporting Alleged Marketing Violations

To ensure the fair and consistent investigation of alleged violations, DHH has outlined the reporting guidelines for handling any allegations in the Dental Benefit Program Companion Guide.

12.13.3. Sanctions

DHH may impose sanctions against the Health Plan for marketing and member education violations as outlined in Section 20 of this RFP.

12.14. Member Materials

The Health Plan shall include in all member materials the following:

12.14.1.

The date of issue;

12.14.2.

The date of revision; and/or

12.14.3.

If prior versions are obsolete.

13. Member and State Fair Hearing Procedures

The Health Plan must have a grievance system that complies with 42 CFR, Part 438, Subpart F. The Health Plan shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance with all applicable state and federal laws.

The Health Plan's grievance and appeals procedures must be submitted prior to the Readiness Review for review and approval and any changes thereto must be approved in writing by DHH prior to their implementation and must include at a minimum the requirements set forth in this RFP.

The Health Plan shall refer all Health Plan members who are dissatisfied with the Health Plan or its subcontractor in any respect to the Health Plan's designee authorized to review and respond to grievances and appeals and require corrective action.

The member must exhaust the Health Plan's internal grievance/appeal procedures prior to accessing the State Fair Hearing process.

The Health Plan shall not create barriers to timely due process. The Health Plan shall be subject to sanctions if it is determined by DHH that the Health Plan has created barriers to timely due process, and/or, if ten (10) percent or higher of grievance decisions appealed to the State Fair Hearing level within a twelve (12) month period have been reversed or otherwise resolved in favor of the member. Examples of creating barriers shall include but not be limited to:

- Labeling complaints as inquiries and funneled into an informal review;
- Failing to inform members of their due process rights;
- Failing to log and process grievances and appeals;
- Failure to issue a proper notice including vague or illegible notices;
- Failure to inform of continuation of benefits; and
- Failure to inform of right to State Fair Hearing.

13.1. Applicable Definitions

13.1.1. Definition of Action

For purposes of this RFP an action is defined as:

- The denial or limited authorization of a requested service, including the type or level of service; or
- The reduction, suspension, or termination of a previously authorized service; or
- The denial, in whole or in part, of payment for a service; or
- The failure to provide services in a timely manner, as defined by Sections 7.3 and 7.5; or
- The failure of the Health Plan to act within the timeframes provided in Section 13.12.1 of this RFP.

13.1.2. Definition of Appeal

For purposes of this RFP an appeal is defined as a request for review of an action, as "action" is defined in Section 24, Glossary.

13.1.3. Definition of Grievance

For purposes of this RFP, a grievance is defined as an expression of dissatisfaction about any matter other than an action, as "action" is defined in Section 24, Glossary.

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Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

The term is also used to refer to the overall system that includes grievances and appeals handled at the Health Plan level.

13.2. General Grievance System Requirements

13.2.1. Grievance System

The Health Plan must have a system in place for members that include a grievance process, an appeal process, and access to the State Fair Hearing system, once the Health Plan's appeal process has been exhausted.

13.2.2. Authority to File

13.2.2.1.

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

13.2.2.2.

A network provider, acting on behalf of the member and with the member's written consent, may file an appeal. A network provider may file a grievance or request a State Fair Hearing on behalf of a member,

13.2.3. Time Limits for Filing

The member must be allowed thirty (30) calendar days from the date on the Health Plan's notice of action or inaction to file a grievance or appeal. Within that timeframe the member or a representative acting on their behalf may file an appeal or the provider may file an appeal on behalf of the member, and with the member's written consent.

13.2.4. Procedures for Filing

The member may file a grievance either orally or in writing with the Health Plan.

The member or a representative acting on their behalf, or the provider, acting on behalf of the member and with the member's written consent, may file an appeal either orally or in writing; and unless he or she orally requests an expedited resolution and follows up with a written, signed appeal request.

13.3. Notice of Grievance and Appeal Procedures

The Health Plan shall ensure that all Health Plan members are informed of the State Fair Hearing process and of the Health Plan's grievance and appeal procedures. The Health Plan shall provide to each member a member handbook that shall include descriptions of the Health Plan's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the Health Plan shall be available through the Health Plan, and must be provided upon request of the member. The Health Plan shall make all forms easily available on the Health Plan's website.

13.4. Grievance/Appeal Records and Reports

13.4.1.

The Health Plan must maintain records of all grievances and appeals. A copy of grievances logs and records of disposition of appeals shall be retained for six (6) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six (6) year period, whichever is later.

13.4.2.

The Health Plan shall electronically provide DHH with a monthly report of the grievances/appeals in accordance with the requirements outlined in this RFP, to include, but not be limited to: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; resolution and resulting corrective action. Reports with personally identifying information redacted will be made available for public inspection.

13.4.3.

The Health Plan will be responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the Health Plan member. DHH may submit recommendations to the Health Plan regarding the merits or suggested resolution of any grievance/appeal.

13.5. Handling of Grievances and Appeals

13.5.1. General Requirements

In handling grievances and appeals, the Health Plan must meet the following requirements:

13.5.1.1.

Acknowledge receipt of each grievance and appeal in writing;

13.5.1.2.

Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;

13.5.1.3.

Ensure that the individuals who make decisions on grievances and appeals are individuals:

13.5.1.3.1.

Who were not involved in any previous level of review or decision-making; and

13.5.1.3.2.

Who, if deciding any of the following, are healthcare professionals who have the appropriate clinical expertise, as determined by DHH, in treating the member's condition or disease:

- An appeal of a denial that is based on lack of medical necessity.
- A grievance regarding denial of expedited resolution of an appeal.
- A grievance or appeal that involves clinical issues.

13.5.2. Special Requirements for Appeals

The process for appeals must:

13.5.2.1.

Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal), unless the member or the provider requests expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing; however if filed orally the requestor must follow up in writing. No additional member follow-up is required.

13.5.2.2.

Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The Health Plan must inform the member of the limited time available for this in the case of expedited resolution).

13.5.2.3.

Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process.

13.5.2.4.

Include, as parties to the appeal:

- The member and his or her representative; or
- The legal representative of a deceased member's estate.

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13.5.3. Training of Health Plan Staff

The Health Plan's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.

13.5.4. Identification of Appropriate Party

The appropriate individual or body within the Health Plan having decision making authority as part of the grievance/appeal procedure shall be identified.

13.5.5. Failure to Make a Timely Decision

Appeals shall be resolved no later than stated time frames and all parties shall be informed of the Health Plan's decision. If a determination is not made in accordance with the timeframes specified in Section 13.7 of this RFP, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

13.5.6. Right to State Fair Hearing

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

13.6. Notice of Action

13.6.1. Language and Format Requirements

The notice must be in writing and must meet the language and format requirements of 42 C.F.R. §438.10(c) and (d) and Section 12 to ensure ease of understanding.

13.6.2. Content of Notice of Action

The Notice of Action must explain the following:

- The action the Health Plan or its contractor has taken or intends to take;
- The reasons for the action;
- The member's or the provider's right to file an appeal with the Health Plan;
- The member's right to request a State Fair Hearing, after the Health Plan's appeal process has been exhausted;
- The procedures for exercising the rights specified in this section
- The circumstances under which expedited resolution is available and how to request it;
- The member's right to have benefits continued pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services; and
- Oral interpretation is available for all languages and how to access it.

13.6.3. Timing of Notice of Action

The Health Plan must mail the Notice of Action within the following timeframes:

13.6.3.1.

For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action, except when the period of advanced notice is shortened to five days if probable member fraud has been verified by the date of the action for the following:

- In the death of a member,
- A signed member statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information),
- The member's admission to an institution where he is ineligible for further services,
- The member's address is unknown and mail directed to him has no forwarding address,
- The member has been accepted for Medicaid services by another local jurisdiction, or
- The member's dentist prescribes the change in the level of medical care as permitted under 42 C.F.R. §431.213 and §431.214.

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13.6.3.2.

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

13.6.3.3.

For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if

13.6.3.3.1.

The member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or

13.6.3.3.2.

The Health Plan justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.

13.6.3.4.

If the Health Plan extends the timeframe in accordance with Section 13.6.3.3.1 or Section 13.6.3.3.2 above, it must:

- Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and
- Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

13.6.3.5.

On the date the timeframe for service authorization as specified in Section 13.11.3.3 expires. Untimely service authorizations constitute a denial and are thus adverse actions.

13.6.3.6.

For expedited service authorization decisions where a provider indicates, or the Health Plan determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Health Plan must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.

13.6.3.7.

The Health Plan may extend the seventy-two (72) hours' time period by up to fourteen (14) calendar days if the member requests an extension, or if the Health Plan justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.

13.6.3.8.

DHH shall conduct random reviews to ensure that members are receiving such notices in a timely manner.

13.7. Resolution and Notification

The Health Plan must dispose of a grievance and resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within the timeframes established in Section 13.7.1 below.

13.7.1. Specific Timeframes

13.7.1.1. Standard Disposition of Grievances

For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the Health Plan receives the grievance. This timeframe may be extended under Section 13.7.2.

13.7.1.2. Standard Resolution of Appeals

For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the Health Plan receives the appeal. This timeframe may be extended under Section 13.7.2.

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13.7.1.3. Expedited Resolution of Appeals

For expedited resolution of an appeal and notice to affected parties, the timeframe is established as seventy-two (72) hours after the Health Plan receives the appeal. This timeframe may be extended under Section 13.7.2.

13.7.2. Extension of Timeframes

13.7.2.1.

The Health Plan may extend the timeframes of this section by up to fourteen (14) calendar days if:

- The member requests the extension; or
- The Health Plan shows (to the satisfaction of DHH, upon its request) that there is need for additional information and how the delay is in the member's interest.

13.7.2.2. Requirements Following Timeframe Extension

If the Health Plan extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.

13.7.3. Format of Notice of Disposition

13.7.3.1. Grievances

The Health Plan will provide written notice to the member of the disposition of a grievance.

13.7.3.2. Appeals

For all appeals, the Health Plan must provide written notice of disposition.

13.7.3.3. Expedited Resolution

For notice of an expedited resolution, the Health Plan must also make reasonable efforts to provide oral notice.

13.7.4. Content of Notice of Appeal Resolution

The written notice of the resolution must include the following:

13.7.4.1.

The results of the resolution process and the date it was completed.

13.7.4.2.

For appeals not resolved wholly in favor of the members:

- The right to request a State Fair Hearing, and how to do so;
- The right to request to receive benefits while the hearing is pending, and how to make the request; and
- That the member may be held liable for the cost of those benefits if the hearing decision upholds the Health Plan's action.

13.7.5. Requirements for State Fair Hearings

DHH shall comply with the requirements of 42 CFR §431.200(b), §431.220(5) and 42 CFR §438.414 and §438.10(g)(1). The Health Plan shall comply with all requirements as outlined in this RFP.

13.7.5.1. Availability

If the member has exhausted the Health Plan level appeal procedures, the member may request a State Fair Hearing within thirty (30) days from the date of the Health Plan's notice of resolution.

13.7.5.2. Parties

The parties to the State Fair Hearing include the Health Plan as well as the member and his or her representative or the representative of a deceased member's estate.

13.8. Expedited Resolution of Appeals

The Health Plan must establish and maintain an expedited review process for appeals, when the Health Plan determines (for a request from the member) or the provider, acting on behalf of the member and with the member's written consent, indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

13.8.1. Prohibition Against Punitive Action

The Health Plan must ensure that punitive action is neither taken against a provider, acting on behalf of the member and with the member's written consent, who requests an expedited resolution or supports a member's appeal.

13.8.2. Action Following Denial of a Request for Expedited Resolution

13.8.2.1.

If the Health Plan denies a request for expedited resolution of an appeal, it must:

- Transfer the appeal to the timeframe for standard resolution in accordance with Section 12.20.1;
- Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

13.8.2.2.

This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.

13.8.3. Failure to Make a Timely Decision

Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the Health Plan's decision. If a determination is not made by the above timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

13.8.4. Process

The Health Plan shall be required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. Appeals filed orally must be followed up in writing. No additional follow-up may be required.

The Health Plan shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

13.8.5. Authority to File

The Medicaid member or their provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional member follow-up is required.

13.8.6. Format of Resolution Notice

In addition to written notice, the Health Plan must also make reasonable effort to provide oral notice.

13.9. Continuation of Benefits

13.9.1. Terminology

As used in this section, "timely" filing means filing on or before the later of the following:

- Within ten (10) calendar days of the Health Plan mailing the notice of action.
- The intended effective date of the Health Plan's proposed action.

13.9.2. Continuation of Benefits

The Health Plan must continue the member's benefits if:

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

13.9.3. Duration of Continued or Reinstated Benefits

If, at the member's request, the Health Plan continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

- The member withdraws the appeal.
- Ten (10) calendar days pass after the Health Plan mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached.
- A State Fair Hearing Officer issues a hearing decision adverse to the member.
- The time period or service limits of a previously authorized service has been met.

13.9.4. Member Responsibility for Services Furnished While the Appeal is Pending

If the final resolution of the appeal is adverse to the member, that is, upholds the Health Plan's action, the Health Plan may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this Section, and in accordance with the policy set forth in 42 CFR §431.230(b).

13.10. Information to Providers and Contractors

The Health Plan must provide the information specified at 42 CFR §438.10(g)(1) about the grievance system to all providers and contractors at the time they enter into a contract.

13.11. Recordkeeping and Reporting Requirements

Reports of grievances and resolutions shall be submitted to DHH as specified in Section 0. The Health Plan shall not modify the grievance procedure without the prior written approval of DHH.

13.12. Services Not Furnished While the Appeal is Pending

If the Health Plan or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Health Plan must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires.

13.13. Services Furnished While the Appeal is Pending

If the Health Plan or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Health Plan must pay for those services, in accordance with this Contract.

14. Quality Management

14.1. Quality Assessment and Performance Improvement Program (QAPI)

14.1.1.

The Health Plan shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program, as described in 42 CFR 438.240(a)(1), to:

14.1.1.1.

Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities;

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14.1.1.2.

Incorporate improvement strategies that include, but are not limited to:

- performance improvement projects;
- medical record audits;
- performance measures; and
- surveys

14.1.1.3.

Detect underutilization and overutilization of services

14.1.1.4.

Assess the quality and appropriateness of dental care furnished to enrollees with special healthcare needs.

14.1.2.

The QAPI Program's written policies and procedures shall address components of effective healthcare management and define processes for ongoing monitoring and evaluation that will promote quality of care. High risk and high volume areas of patient care should receive priority in selection of QAPI activities.

14.1.3.

The QAPI Program shall define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.

14.1.4.

The Health Plan shall submit its QAPI Program description to DHH for written approval within thirty (30) days from the date the Contract is signed, but no later than prior to the Readiness Review.

14.1.5.

The Health Plan's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the Health Plan's governing body shall include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the Health Plan.

14.2. QAPI Committee

The Health Plan shall form a QAPI Committee that shall, at a minimum include:

14.2.1. QAPI Committee Members

14.2.1.1.

The Health Plan Dental Director must serve as either the chairman or co-chairman;

14.2.1.2.

Appropriate Health Plan staff representing the various departments of the organization will have membership on the committee; and

14.2.1.3.

The Health Plan is encouraged to include a member advocate representative on the QAPI Committee.

14.2.2. QAPI Committee Responsibilities

14.2.2.1.

The committee shall meet on a quarterly basis

14.2.2.2.

Direct and review quality improvement (QI) activities;

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14.2.2.3.

Assure that QAPI activities are implemented throughout the Health Plan;

14.2.2.4.

Review and suggest new and or improved QI activities;

14.2.2.5.

Direct task forces/committees to review areas of concern in the provision of healthcare services to members;

14.2.2.6.

Designate evaluation and study design procedures;

14.2.2.7.

Conduct individual primary care dentist and primary care dentist practice quality performance measure profiling;

14.2.2.8.

Report findings to appropriate executive authority, staff, and departments within the Health Plan;

14.2.2.9.

Direct and analyze periodic reviews of members' service utilization patterns;

14.2.2.10.

Maintain minutes of all committee and sub-committee meetings and submit a summary of the meeting minutes to DHH within ten (10) business days following each meeting;

14.2.2.11.

Report an evaluation of the impact and effectiveness of the QAPI program to DHH annually. This report shall include, but is not limited to, all care management activities; and

14.2.2.12.

Ensure that a QAPI committee designee attends DHH Quality Committee meetings.

14.2.3. QAPI Work Plan

The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to DHH within thirty (30) calendar days from the date the Contract with DHH is signed, but no later than prior to the Readiness Review, by the Health Plan and annually thereafter, and prior to revisions. The QAPI plan, at a minimum, shall:

14.2.3.1.

Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;

14.2.3.2.

Include processes to evaluate the impact and effectiveness of the QAPI Program;

14.2.3.3.

Include a description of the Health Plan staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and

14.2.3.4.

Describe the role of its providers in giving input to the QAPI Program.

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14.2.4. QAPI Reporting Requirements

14.2.4.1.

The Health Plan shall submit QAPI reports annually to DHH which, at a minimum, shall include:

- Quality improvement (QI) activities;
- Recommended new and/or improved QI activities; and
- Evaluation of the impact and effectiveness of the QAPI program.

14.2.4.2.

DHH reserves the right to request additional reports as deemed necessary. DHH will notify the Health Plan of additional required reports no less than sixty (60) days prior to due date of those reports.

14.3. Performance Measures

14.3.1.

The Health Plan shall report clinical and administrative performance measure (PM) data on at least an annual basis, as specified by DHH and in accordance with the specifications of the Health Plan Quality Companion Guide-.

14.3.1.1.

The Health Plan shall report on PMs listed in Appendix F which include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality Review (AHRQ), Dental Quality Alliance (DQA), National Committee Quality Measures (NCQM), and/or other measures as determined by DHH.

14.3.1.2.

The Health Plan shall have processes in place to monitor and report all performance measures.

14.3.1.3.

Clinical PM outcomes shall be submitted to DHH at least annually and upon DHH request. Detailed data shall be made available to support any summary report of Clinical outcomes QIPs.

14.3.1.4.

Administrative PMs shall be submitted to DHH at least quarterly and upon DHH request. Detailed data shall be made available to support any summary report of Administrative QIPs.

14.3.1.5.

The reports and data shall demonstrate adherence to clinical practice guidelines and shall demonstrate changes in patient outcomes.

14.3.1.6.

Performance measures may be used to create PIPs which are the Health Plan's activities to design, implement and sustain systematic improvements based on their own data.

14.3.2. Performance Measures Reporting

14.3.2.1.

All Administrative PMs are reporting measures.

- Administrative measure reporting is required at least quarterly and upon DHH request.
- Clinical Performance measures shall be reported at least annually and upon DHH request 12 months after services begin.

14.3.2.2.

DHH may add or remove PM reporting requirements with a sixty (60) day advance notice.

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14.3.3. Performance Measure Goals

The Department shall establish benchmarks for Performance Measures utilizing statewide data of the Medicaid Fee for Service Population with the expectation that performance improves by a certain percentage toward the benchmarks.

Goals will be set for 2013 Performance Measures utilizing baseline from the Health Plan outcomes received in 2012.

14.3.4. Performance Indicator Reporting Systems

14.3.4.1.

The Health Plan shall utilize DHH-approved systems, operations, and performance monitoring tools and/or automated methods for monitoring. Access to such systems and tools shall be granted to DHH as needed for oversight.

14.3.4.2.

The monitoring tools and reports shall be flexible and adaptable to changes in the quality measurements required by DHH.

14.3.4.3.

The Health Plan shall have processes in place to monitor and self-report performance measures included by not limited to measures listed in Appendix F.

14.3.4.4.

The Health Plan shall provide individual primary care dentist clinical quality profile reports as indicated in Section 8.7.

14.3.5. Performance Measure Monitoring

14.3.5.1.

DHH will monitor the Health Plan's performance using Benchmark Performance and Improvement Performance data.

14.3.5.2.

During the course of the Contract, DHH or its designee shall communicate with the Health Plan regarding the data and reports received as well as meet with representatives of the Health Plan to review the results of performance measures.

14.3.5.3.

The Health Plan shall comply with External Quality Review, review of the Quality Assessment Committee meeting minutes and annual medical audits to ensure that it provides quality and accessible healthcare to Health Plan members, in accordance with standards contained in the Contract. Such audits shall allow DHH or its duly authorized representative to review individual medical records, identify and collect management data, including but not limited to, surveys and other information concerning the use of services and the reasons for member disenrollment.

14.3.5.4.

The standards by which the Health Plan shall be surveyed and evaluated will be at the sole discretion and approval of DHH. If deficiencies are identified, the Health Plan must formulate a Corrective Action Plan (CAP) incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. DHH must prior approve the CAP and will monitor the Health Plan's progress in correcting the deficiencies.

14.3.6. Performance Measure Corrective Action Plan

A corrective action plan (CAP) shall be required for performance measures that do not reach the Department's performance benchmark.

14.3.6.1.

The Health Plan shall submit a CAP, within thirty (30) calendar days of the date of notification or as specified by DHH, for the deficiencies identified by DHH.

14.3.6.2.

Within thirty (30) calendar days of receiving the CAP, DHH will either approve or disapprove the CAP. If disapproved, the Health Plan shall resubmit, within fourteen (14) calendar days, a new CAP that addresses the deficiencies identified by DHH.

14.3.6.3.

Upon approval of the CAP, whether the initial CAP or the revised CAP, the Health Plan shall implement the CAP within the time frames specified by DHH.

14.3.6.4.

DHH may impose monetary penalties, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.

14.4. Member Satisfaction Surveys

14.4.1.

The Health Plan shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members.

14.4.2.

The Health Plan shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The Health Plan's vendor shall perform CAHPS Adult surveys, CAHPS Child surveys, and CAHPS Children with Chronic Conditions survey.

14.4.3.

Survey results and a description of the survey process shall be reported to DHH separately for each required CAHPS survey.

14.4.4.

The survey shall be administered to a statistically valid random sample of clients who are enrolled in the Health Plan at the time of the survey.

14.4.5.

The surveys shall provide valid and reliable data for results in the specific GSA.

14.4.6.

Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.

14.4.7.

The most current CAHPS Health Plan Survey (currently 4.0) for Medicaid Enrollees shall be used and include:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Health Plan Customer Service
- Global Ratings

14.4.8.

Member Satisfaction Survey Reports are due 120 calendar days after the end of the plan year.

14.5. Provider Satisfaction Surveys

14.5.1.

The Health Plan shall conduct an annual provider survey to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, and utilization management processes. The Provider Satisfaction survey tool and methodology must be submitted to DHH for approval prior to administration.

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14.5.2.

The Health Plan shall submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due 120 days after the end of the plan year.

14.6. DHH Oversight of Quality

14.6.1.

DHH shall evaluate the Health Plan's QAPI, PMs, and PIPs at least one (1) time per year at dates to be determined by DHH, or as otherwise specified by the Contract.

14.6.2.

If DHH determines that the Health Plan's quality performance is not acceptable, the Health Plan must submit a corrective action plan (CAP) for each unacceptable performance measure. If the Health Plan fails to provide a CAP within the time specified, DHH will sanction the Health Plan in accordance with the provisions of sanctions set forth in the Contract.

14.6.3.

Upon any indication that the Health Plan's quality performance is not acceptable, DHH may impose sanctions or terminate the contract

14.6.4.

The Health Plan shall cooperate with DHH, the independent evaluation contractor (External Quality Review Organization), and any other Department designees during monitoring.

14.7. External Independent Review

14.7.1.

The Health Plan shall provide all information requested by the External Quality Review Organization (EQRO) and/or DHH including, but not limited to, quality outcomes concerning timeliness of, and member access to, core benefits and services.

14.7.2.

The Health Plan shall cooperate with the EQRO during the review (including medical records review), which will be done at least one (1) time per year.

14.7.3.

If the EQRO indicates that the quality of care is not within acceptable limits set forth in the Contract, DHH may sanction the Health Plan in accordance with the provisions of Section 20.

14.7.4.

A description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQR findings shall be included in the Health Plan's QAPI program. DHH may also require separate submission of an improvement plan specific to the findings of the EQRO.

14.8. Credentialing and Re-credentialing of Providers and Clinical Staff

14.8.1.

The Health Plan must have a written credentialing and re-credentialing process that complies with 42 CFR 438.12, 438.206, 438.214, 438.224 and 438.230 for the review and credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the Health Plan selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted as part of the Proposal, when a change is made, and annually thereafter.

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14.8.2.

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

14.8.3.

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

14.8.4.

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

14.8.5.

The Health Plan shall develop and implement a mechanism, with DHH's approval, for reporting quality deficiencies which result in suspension or termination of a network provider/ subcontractor(s). This process shall be submitted for review and approval thirty (30) calendar days from the date the Contract is signed, but no later than 30 calendar days prior to the Readiness Review, and at the time of any change.

14.8.6.

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

14.8.7.

This process shall be submitted for review and approval thirty (30) calendar days from the date the Contract is signed, but no later than 30 calendar days prior to the Readiness Review, and at the time of any change.

15. Fraud, Abuse, and Waste Prevention

15.1. General Requirements

15.1.1.

The Health Plan shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs.

15.1.2.

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

15.1.3.

The Health Plan shall cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, HHS, the Legislative Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, DHH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of six (6) years from the expiration date of the Contract (including any extensions to the Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the Contract and any other applicable rules.

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15.1.4.

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

15.1.5.

Health Plan's employees and its contractors and their employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.

15.1.6.

The Health Plan shall provide access to DHH and/or its designee to all information related to grievances and appeals filed by its members. DHH shall monitor enrollment and termination practices and ensure proper implementation of the Health Plan's grievance procedures, in compliance with 42 CFR §§ 438.226-438.228 (2006, as amended).

15.1.7.

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

15.1.8.

The Health Plan shall report to DHH, within three (3) business days, when it is discovered that any Health Plan employees, network provider, contractor, or contractor's employees have been excluded, suspended, or debarred from any state or federal healthcare benefit program.

15.2. Fraud and Abuse Compliance Plan

15.2.1.

In accordance with 42 CFR 438.608(a), the Health Plan shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.

15.2.2.

In accordance with 42 CFR 438.608(b)(2), the Health Plan shall designate a compliance officer and compliance committee that have the responsibility and authority for carrying out the provisions of the compliance program. These individuals shall be accountable to the Health Plan's board of directors and shall be directly answerable to the Executive Director or to the board of directors and senior management. The Health Plan shall have an adequately staffed Medicaid compliance office with oversight by the compliance officer.

15.2.3.

The Health Plan shall submit the Fraud and Abuse Compliance Plan within thirty (30) calendar days from the date the Contract is signed with the Health Plan, but no later than thirty (30) calendar days prior to the Readiness Review. The Health Plan shall submit updates or modifications to DHH for approval at least thirty (30) calendar days in advance of making them effective. DHH, at its sole discretion, may require that the Health Plan modify its compliance plan. The Health Plan compliance program shall incorporate the policy and procedures specified in Appendix U – Coordination of DBP Fraud and Abuse Complaints and Referrals and shall incorporate the following:

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15.2.3.1.

Written policies, procedures, and standards of conduct that articulate Health Plan's commitment to comply with all applicable federal and state standards;

15.2.3.2.

Effective lines of communication between the compliance officer and the Health Plan's employees, providers and contractors enforced through well-publicized disciplinary guidelines;

15.2.3.3.

Procedures for ongoing monitoring and auditing of Health Plan systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous quality improvement activities, and provider activities;

15.2.3.4.

Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the 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;

15.2.3.5.

Provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR 438.608(b)(4-6);

15.2.3.6.

Protections to ensure that no individual who reports compliance plan violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the Health Plan. The Health Plan shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible. Anyone who believes that he or she has been retaliated against may report this violation to the Louisiana Medicaid Office of Program Integrity and/or the U.S. Office of Inspector General.

15.2.3.7.

Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract in accordance with 42 CFR 438.608(b)(7);

15.2.3.8.

Well-publicized disciplinary procedures that shall apply to employees who violate the Health Plan's compliance program;

15.2.3.9.

Effective training and education for the compliance officer, managers, employees, providers and members to ensure that they know and understand the provisions of Health Plan's compliance plan;

15.2.3.10.

Procedures for timely consistent exchange of information and collaboration with the DHH Program Integrity Unit; and

15.2.3.11.

Provisions that comply with 42 CFR 438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.

15.3. Prohibited Affiliations

15.3.1.

In accordance with 42CFR 438.610, the Health Plan is prohibited from knowingly having a relationship with:

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15.3.1.1.

An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The Health Plan shall comply with all applicable provisions of 42 CFR Part 376 (2009, as amended), pertaining to debarment and/or suspension. The Health Plan shall screen all employees and contractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal healthcare programs. To help make this determination, the Health Plan shall search the following websites:

- Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) <http://exclusions.oig.hhs.gov/search.aspx> ;
- Healthcare Integrity and Protection Data Bank (HIPDB)
- <http://www.npdb-hipdb.hrsa.gov/index.jsp> ; and
- Excluded Parties List Serve (EPLS)

www.EPLS.gov

15.3.1.2.

The Health Plan shall conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered should be immediately reported to DHH. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR 1003.102(a)(2).

15.3.1.3.

An individual who is an affiliate of a person described above and include:

- A director, officer, or partner of the Health Plan;
- A person with beneficial ownership of 5 percent or more of the Health Plan's equity; or
- A person with an employment, consulting or other arrangement with the Health Plan for the provision of items and services which are significant and material to the Health Plan's obligations.

15.3.1.4.

The Health Plan shall notify DHH within three (3) business days of the time it receives notice that action is being taken against the Health Plan or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the Health Plan or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

15.4. Excluded Providers

Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for emergency services.

15.5. Reporting

15.5.1.

In accordance with 42 CFR §§ 455.1(a)(1) and 455.17, the Health Plan shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the State Office and Attorney General Medicaid Fraud Control Unit (MFCU) and DHH within five (5) business days of discovery, taking prompt corrective actions and cooperating with DHH in its investigation of the matter(s). Additionally, the Health Plan shall notify DHH within three (3) business days of the time it receives notice that action is being taken against the Health Plan or Health Plan employee, network providers contractor or contractor employee or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any

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contractor which could result in exclusion, debarment, or suspension of the Health Plan or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

15.5.2.

The Health Plan, through its compliance officer, shall report all activities on a quarterly basis to DHH. If fraud, abuse, waste, neglect and overpayment issues are suspected, the Health Plan compliance officer shall report it to DHH immediately upon discovery. Reporting shall include, but are not limited to:

15.5.2.1.

Number of complaints of fraud, abuse, waste, neglect and overpayments made to the Health Plan that warrant preliminary investigation;

15.5.2.2.

Number of complaints reported to the Compliance Officer; and

15.5.2.3.

For each complaint that warrants investigation, the Health Plan shall provide DHH, at a minimum, the following:

- Name and ID number of provider and member involved if available;
- Source of complaint;
- Type of provider;
- Nature of complaint;
- Approximate dollars involved if applicable; and
- Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.

15.6. Medical Records

15.6.1.

The Health Plan shall have a method to verify that services for which reimbursement was made, was provided to members. The Health Plan shall have policies and procedures to maintain, or require Health Plan providers and contractors to maintain, an individual medical record for each member. The Health Plan shall ensure the medical record is:

15.6.1.1.

Accurate and legible;

15.6.1.2.

Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or treated, and is accessible for review and audit; and

15.6.1.3.

Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.

15.6.2.

The Health Plan shall ensure the medical record includes, minimally, the following:

15.6.2.1.

Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);

15.6.2.2.

Primary language spoken by the member and any translation needs of the member;

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15.6.2.3.

Services provided through the Health Plan, date of service, service site, and name of service provider;

15.6.2.4.

Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the Health Plan;

15.6.2.5.

Referrals including follow-up and outcome of referrals;

15.6.2.6.

Documentation of emergency and/or after-hours encounters and follow-up;

15.6.2.7.

Signed and dated consent forms (as applicable);

15.6.2.8.

Documentation of advance directives, as appropriate; and

15.6.2.9.

Documentation of each visit, which must include:

- Date and begin and end times of service;
- Chief complaint or purpose of the visit;;
- Diagnoses or medical impression;
- Objective findings;
- Patient assessment findings;
- Studies ordered and results of those studies (e.g. laboratory, x-ray, EKG);
- Medications prescribed;
- Health education provided;
- Name and credentials of the provider rendering services (e.g. DDS) and the signature or initials of the provider; and
- Initials of providers must be identified with correlating signatures.

15.6.3.

The Health Plan must provide one (1) free copy of any part of member's record upon member's request.

15.6.4.

All documentation and/or records maintained by the Health Plan or any and all of its network providers shall be maintained for at least six (6) years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.

16. Systems and Technical Requirements

16.1. General Requirements

16.1.1.

The Health Plan shall maintain an automated Management Information System (MIS), hereafter referred to as System, which accepts and processes provider claims, verifies eligibility, collects and reports encounter data and validates prior authorization that complies with DHH and federal reporting requirements. The Health Plan shall ensure that its System meets the requirements of the Contract, state issued Guides (See DBP Systems Companion Guide) and all applicable state and federal laws, rules and regulations, including Medicaid confidentiality and HIPAA and American Recovery and Reinvestment Act (ARRA) privacy and security requirements.

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16.1.2.

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

16.1.3.

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

16.1.4.

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

16.2. HIPAA Standards and Code Sets

16.2.1.

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

16.2.2.

All HIPAA-conforming exchanges of data between DHH and the Health Plan shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker. The HIPAA Business Associate Agreement (Attachment D) shall become a part of the Contract.

16.2.3.

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

- ASC X12N 835 Claims Payment Remittance Advice Transaction;
- ASC X12N 837I Institutional Claim/Encounter Transaction;
- ASC X12N 837D Dental Claim/Encounter
- ASC X12N 837P Professional Claim/Encounter Transaction;
- ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;
- ASC X12N 276 Claims Status Inquiry;
- ASC X12N 277 Claims Status Response;
- ASC X12N 278 Utilization Review Inquiry/Response; and
- ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products.

16.2.4.

The Health Plan shall not revise or modify the standardized forms or formats.

16.2.5.

Transaction types are subject to change and the Health Plan shall comply with applicable federal and HIPAA standards and regulations as they occur.

16.2.6.

The Health Plan shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with DHH. These shall include, but not be limited to, HIPAA based standards, federal safeguard requirements including signature requirements described in the CMS State Medicaid Manual.

16.3. Connectivity

16.3.1.

DHH shall require that the Health Plan interface with DHH, the Medicaid Fiscal Intermediary (FI), and its trading partners. The Health Plan must have capacity for real time connectivity to all DHH approved systems. The Health Plan must have the capability to allow approved DHH personnel to access internal applications to permit inquiry of eligibility, claims, encounters, reference, provider and other data. The access method should be real-time and may be coordinated with DHH via remote network connections.

16.3.2.

The System shall conform and adhere to the data and document management standards of DHH and its FI, inclusive of standard transaction code sets.

16.3.3.

The Health Plan's Systems shall utilize mailing address standards in accordance with the United States Postal Service.

16.3.4. .

At such time that DHH requires, the Health Plan shall participate and cooperate with DHH to implement, within a reasonable timeframe, a secure, web-accessible health record for members, such as Personal Health Record (PHR) or Electronic Health Records (EHR).

16.3.5.

At such time that DHH requires, the Health Plan shall participate in statewide efforts to incorporate all provider information into a statewide health information exchange.

16.3.6.

The Health Plan shall meet, as requested by DHH, with work groups or committees to coordinate activities and develop system strategies that actively reinforce the healthcare reform initiative.

16.3.7.

All information, whether data or documentation and reports that contain or references to that information involving or arising out of the Contract is owned by DHH. The Health Plan is expressly prohibited from sharing or publishing DHH's information and reports without the prior written consent of DHH. In the event of a dispute regarding the sharing or publishing of information and reports, DHH's decision on this matter shall be final.

16.3.8.

The Medicaid Management Information System (MMIS) is responsible for the payment of FFS, Bayou Health Shared Savings Plans and Bayou Health Prepaid Health Plans claims to providers and the timely and accurate reporting to state and federal personnel and private sector partners for covered Medicaid services. MMIS processes 64 million original paid Medicaid claims annually for more than 30,000 Medicaid providers. The Medicaid Fiscal Intermediary (FI) contract is currently with Molina Healthcare Solutions, Inc. DHH's current MMIS contract expired on December 31, 2009, however DHH has exercised its right to extend all or part of the (5) year extension to its current FI. DHH is in the middle of the third one year contract extension. In the first quarter of 2012, DHH contracted with CNSI to become the new FI for the state of Louisiana. Design Development and Implementation (DDI) activities surrounding the CNSI system are currently ongoing with the implementation of the new system slated for January 2015. DHH shall require the Health Plan to comply with transitional requirements as necessary with a new FI during the Contract at no cost to DHH or its FI.

16.3.9.

The Health Plan shall be responsible for all initial and recurring costs required for access to DHH system(s), as well as DHH access to the Health Plan's system(s). These costs include, but are not limited to, hardware, software, licensing, and authority/permission to utilize any patents, annual maintenance, support, and connectivity with DHH and the Fiscal Intermediary (FI).

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16.3.10.

The Health Plan shall complete an Information Systems Capabilities Assessment (ISCA), which will be provided by DHH. The ISCA shall be completed and returned to DHH no later than thirty (30) days from the date the Health Plan signs the Contract with DHH.

16.4. Hardware and Software

The Health Plan must maintain hardware and software compatible with current DHH requirements which are as follows:

16.4.1. Desktop Workstation Hardware:

Should be compatible with current personal computer/desktop hardware to support current release of Microsoft Windows operating system and applications software.

16.4.2. Desktop Workstation Software:

- IBM compatible PC
- Intel Core i5 or equivalent (or compatible successors)
- Operating system should be Microsoft Windows XP, SP3 or later version of operating system (minimum),
- Web browser that is equal to or surpasses Microsoft Internet Explorer v8.0 (or later) and is capable of resolving JavaScript and ActiveX scripts;
- DVD\CD ROM
- An email application that is compatible with Microsoft Outlook;
- An office productivity suite such as Microsoft Office that is compatible with Microsoft Office 2007 or later;
- Each workstation should have access to high speed Internet;
- Each workstation connected to the Internet should have installed firewall, anti-virus, anti-spam, and anti-malware software. Regular and frequent updates of the virus definitions and security parameters of these software applications should be established and administered;
- 4 Gig of RAM memory (minimum)
- Enough spare USB ports to accommodate thumb drives, etc.
- 250GB Hard Drive (minimum)
- Ethernet LAN interface for laptop and desktop PCs
- 19" WXGA Digital Flat Panel LCD monitor with DVI (minimum)
- Printer compatible with hardware and software required
- A desktop compression/encryption application that is compatible with WinZIP v14.0 or later;
- All workstations, laptops and portable communication devices shall be installed with full disk encryption software; and
- Compliant with industry-standard physical and procedural safeguards for confidential information (NIST 800-53A, ISO 17788, etc.).

16.4.3. Network and Back-up Capabilities

- Establish a local area network or networks as needed to connect all appropriate workstation personal desktop computers (PCs);
- Establish appropriate hardware firewalls, routers, and other security measures so that the Health Plan's computer network is not able to be breached by an external entity;
- Establish appropriate back-up processes that ensure the back-up, archival, and ready retrieval of network server data and desktop workstation data;
- Ensure that network hardware is protected from electrical surges, power fluctuations, and power outages by using the appropriate uninterruptible power system (UPS) and surge protection devices; and
- The Health Plan shall establish independent generator back-up power capable of supplying necessary power for a minimum of four (4) days.

16.5. Resource Availability and Systems Changes

16.5.1. Resource Availability

The Health Plan shall provide Systems Help Desk services to DHH, its FI staff that have direct, real-time access to the data in the Health Plan's Systems. The Systems Help Desk shall:

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

16.5.2. Information Systems Documentation Requirements

16.5.2.1.

The Health Plan shall ensure that written Systems process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.

16.5.2.2.

The Health Plan shall develop, prepare, print, maintain, produce, and distribute to DHH distinct Systems design and management manuals, user manuals and quick reference Guides, and any updates.

16.5.2.3.

The Health Plan shall ensure the Systems user manuals contain information about, and instruction for, using applicable Systems functions and accessing applicable system data.

16.5.2.4.

The Health Plan shall ensure when a System change is subject to DHH prior written approval, the Health Plan will submit revision to the appropriate manuals before implementing said Systems changes.

16.5.2.5.

The Health Plan shall ensure all aforementioned manuals and reference Guides are available in printed form and on-line; and

16.5.2.6.

The Health Plan shall update the electronic version of these manuals immediately, and update printed versions within ten (10) business days of the update taking effect.

16.5.2.7.

The Health Plan shall provide to DHH documentation describing its Systems Quality Assurance Plan.

16.5.3. Systems Changes

16.5.3.1.

The Health Plan's Systems shall conform to future federal and/or DHH specific standards for encounter data exchange within one hundred twenty (120) calendar days prior to the standard's effective date or earlier, as directed by CMS or DHH.

16.5.3.2.

If a system update and/or change are necessary, the Health Plan shall draft appropriate revisions for the documentation or manuals, and present to DHH thirty (30) days prior to implementation, for DHH review and approval. Documentation revisions shall be accomplished electronically and shall be made available for Department review in an easily accessible, near real-time method. Printed manual revisions shall occur within ten (10) business days of the actual revision.

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16.5.3.3.

The Health Plan shall submit written notice as an alert to DHH within 10 calendar days of identification of a required system update, change or 'fix'. This written notice shall include an overview of the system problem and its potential impact to providers, with the Health Plan's estimated timeframe for implementation of a correction. The Health Plan shall notify DHH of changes to its System within its span of control, ninety (90) calendar days prior to the projected date of the change, or within a timeframe specified and approved by DHH. Changes include, but are not limited to:

16.5.3.4.

Major changes, upgrades, modification or updates to application or operating software associated with the following core production System:

- Claims processing;
- Eligibility and enrollment processing;
- Service authorization management;
- Reference file processing (e.g., procedure formularies, approved diagnoses, provider payment rates, etc.);
- Provider enrollment and data management; and
- Conversions of core transaction management Systems.

16.5.3.5.

The Health Plan shall respond to DHH notification of System problems not resulting in System unavailability according to the following timeframes:

- Within five (5) calendar days of receiving notification from DHH, the Health Plan shall respond in writing to notices of system problems.
- Within fifteen (15) calendar days, the correction shall be made or a written corrective action plan will be due.
- The Health Plan shall correct the deficiency by an effective date to be determined by DHH.
- The Health Plan's Systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.
- The Health Plan shall put in place procedures and measures for safeguarding against unauthorized modification to the Health Plan's Systems.

16.5.3.6.

Unless otherwise agreed to in advance by DHH, the Health Plan shall not schedule Systems unavailability to perform system maintenance, repair and/or upgrade activities to take place during hours that can compromise or prevent critical business operations.

16.5.3.7.

The Health Plan shall work with DHH pertaining to any testing initiative as required by DHH and shall provide sufficient system access to allow testing by DHH and/or its FI of the Health Plan's System.

16.6. Systems Refresh Plan

16.6.1.

The Health Plan shall provide to DHH an annual Systems Refresh Plan. The plan shall outline how Systems within the Health Plan's span of control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors.

16.6.2.

The systems refresh plan shall also indicate how the Health Plan will ensure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the Systems component.

16.7. Other Electronic Data Exchange

16.7.1.

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

16.7.2.

The Health Plan shall implement Optical Character Recognition (OCR) technology that minimizes manual indexing and automates the retrieval of scanned documents.

16.8. Electronic Messaging

16.8.1.

The Health Plan shall provide a continuously available electronic mail communication link (email system) to facilitate communication with DHH. This email system shall be capable of attaching and sending documents created using software compatible with DHH's installed version of Microsoft Office (currently 2010) and any subsequent upgrades as adopted.

16.8.2.

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

16.8.3.

The Health Plan shall comply with national standards for submitting public health information (PHI) electronically and shall set up a secure emailing system with that is password protected for both sending and receiving any personal health information.

16.9. Member Enrollment

The Health Plan shall:

16.9.1.

Receive, process and update enrollment files sent daily by the Fiscal Intermediary;

16.9.2.

Update its eligibility and enrollment databases within twenty-four (24) hours of receipt of said files;

16.9.3.

Transmit to DHH, in the formats and methods specified by DHH, member address changes and telephone number changes;

16.9.4.

Be capable of uniquely identifying (i.e., Master Patient Index) a distinct Medicaid member across multiple populations and Systems within its span of control; and

16.9.5.

Be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by DHH, resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

16.10. Provider Enrollment

At the onset of the DBP Contract and periodically as changes are necessary, DHH shall publish at www.lamedicaid.com the list of Louisiana Medicaid provider types, specialty, and sub-specialty codes. In order to coordinate provider enrollment records,

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the Health Plan shall utilize the published list of Louisiana Medicaid provider types, specialty, and sub-specialty codes in all provider data communications with DHH and the FI. The Health Plan shall provide the following:

16.10.1.

Provider service name, Provider billing name/DBA name, service/practice address (street, city, state, zip+4), billing address (street, city, state, zip+4), alternate practice site address (if appropriate: street, city, state, zip+4), licensing information (including effective date(s)), Tax ID/SSN, National Provider Identifier (NPI), taxonomy and bank direct deposit/EFT payment information;

16.10.2.

All relevant provider ownership information as prescribed by DHH, federal or state laws; and

16.10.3.

Performance of all federal or state mandated exclusion background checks on all providers (owners and managers). The providers shall perform the same for all their employees at least annually.

16.10.4.

Provider enrollment systems shall include, at minimum, the following functionality:

- Audit trail and history of changes made to the provider file;
- Automated interfaces with all licensing and medical boards;
- Automated alerts when provider licenses are nearing expiration;
- Verification and Retention of NPI requirements;
- System generated letters to providers when their licenses are nearing expiration;
- Linkages of individual providers to groups;
- Credentialing information;
- Provider office hours; and
- Provider languages spoken.

16.10.5.

DBP Contactor shall periodically submit provider enrollment information to DHH and the FI as a “registry” in a layout, format, and schedule as determined by DHH. Should DHH and the FI find errors/issues with the registry submissions, the DBP Contractor will resolve to correct the errors within twenty (20) business days.

16.11. Information Systems Availability

The Health Plan shall:

16.11.1.

Not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the Health Plan’s span of control;

16.11.2.

Allow CMS, DHH personnel, agents of the Louisiana Attorney General’s Office or individuals authorized by DHH or the Louisiana Attorney General’s Office and upon request by CMS direct access to its data for the purpose of data mining and review;

16.11.3.

Ensure that critical member and provider Internet and/or telephone-based IVR functions and information functions are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week except during periods of scheduled System unavailability agreed upon by DHH and the Health Plan. Unavailability caused by events outside of the Health Plan’s span of control is outside of the scope of this requirement;

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16.11.4.

Ensure that at a minimum all other System functions and information are available to the applicable system users between the hours of 7a.m. and 7p.m., Central Time, Monday through Friday;

16.11.5.

Ensure that the systems and processes within its span of control associated with its data exchanges with DHH's FI and its contractors are available and operational;

16.11.6.

Ensure that in the event of a declared major failure or disaster, the Health Plan's core eligibility/enrollment and claims processing system shall be back on line within seventy-two (72) hours of the failure's or disaster's occurrence;

16.11.7.

Notify designated DHH staff via phone, fax and/or electronic mail within sixty (60) minutes upon discovery of a problem within or outside the Health Plan'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 Health Plan and DHH or DHH's FI. In its notification, the Health Plan shall explain in detail the impact to critical path processes such as enrollment management and encounter submission processes;

16.11.8.

Notify designated DHH staff via phone, fax, and/or electronic mail within fifteen (15) minutes upon discovery of a problem that results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocol;

16.11.9.

Provide information on System unavailability events, as well as status updates on problem resolution, to appropriate DHH staff. At a minimum these updates shall be provided on an hourly basis and made available via phone and/or electronic mail, and;

16.11.10.

Resolve and implement system restoration within sixty (60) minutes of official declaration of unscheduled System unavailability of critical functions caused by the failure of system and telecommunications technologies within the Health Plan's span of control. Unscheduled System unavailability to all other System functions caused by system and telecommunications technologies within the Health Plan'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 Health Plan's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period; and

16.11.11.

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

16.12. Contingency Plan

16.12.1.

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

16.12.2.

Contingency plans shall include a disaster recovery plan (DRP) and a business continuity plan (BCP). A DRP is designed to recover systems, networks, workstations, applications, etc. in the event of a disaster. A BCP shall focus on restoring the

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operational function of the organization in the event of a disaster and includes items related to IT, as well as operational items such as employee notification processes and the procurement of office supplies needed to do business in the emergency mode operation environment. The practice of including both the DRP and the BCP in the contingency planning process is a best practice.

16.12.3.

The Health Plan shall have a Contingency Plan that must be submitted to DHH for approval no later than thirty (30) calendar days from the date the Contract is signed, but no later than thirty (30) calendar days prior to the Readiness Review.

16.12.4.

At a minimum, the Contingency Plan shall address the following scenarios:

16.12.4.1.

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

16.12.4.2.

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

16.12.4.3.

System interruption or failure resulting from network, operating hardware, software or operations errors that compromise the integrity of data maintained in a live or archival system;

16.12.4.4.

System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system, but does prevent access to the System, such as it causes unscheduled System unavailability; and

16.12.4.5.

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

16.12.5.

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

16.12.6.

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

16.13. Off Site Storage and Remote Back-up

16.13.1.

The Health Plan shall provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.

16.13.2.

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

16.13.2.1.

Descriptions of the controls for back-up processing, including how frequently back-ups occur;

16.13.2.2.

Documented back-up procedures;

16.13.2.3.

The location of data that has been backed up (off-site and on-site, as applicable);

16.13.2.4.

Identification and description of what is being backed up as part of the back-up plan; and

16.13.2.5.

Any change in back-up procedures in relation to the Health Plan's technology changes.

16.13.3.

DHH shall be provided with a list of all back-up files to be stored at remote locations and the frequency with which these files are updated.

16.14. Records Retention

16.14.1.

The Health Plan shall have online retrieval and access to documents and files for six (6) years in live systems for audit and reporting purposes, ten (10) years in archival systems. Services which have a once in a life-time indicator (i.e., Surgical Removal of Erupted Tooth) are denoted on DHH's procedure formulary file and claims shall remain in the current/active claims history that is used in claims editing and are not to be archived or purged. Online access to claims processing data shall be by the Medicaid recipient ID, provider ID and/or ICN (internal control number) to include pertinent claims data and claims status. The Health Plan shall provide forty-eight (48) hour turnaround or better on requests for access to information that is six (6) years old, and seventy-two (72) hour turnaround or better on requests for access to information in machine readable form, that is between six (6) to ten (10) years old. If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

16.14.2.

The historical encounter data submission shall be retained for a period not less than six (6) years, following generally accepted retention guidelines.

16.14.3.

Audit Trails shall be maintained online for no less than six (6) years; additional history shall be retained for no less than ten (10) years and shall be provide forty-eight (48) hour turnaround or better on request for access to information in machine readable form, that is between six (6) to ten (10) years old.

16.15. Information Security and Access Management

The Health Plan's system shall:

16.15.1.

Employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

16.15.1.1.

Restrict access to information on a "least privilege" basis, such as users permitted inquiry privileges only, will not be permitted to modify information;

16.15.1.2.

Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions shall be restricted to specified staff jointly agreed to by DHH and the Health Plan; and

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16.15.1.3.

Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.

16.15.2.

Make System information available to duly authorized representatives of DHH and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

16.15.3.

Contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed by the Health Plan and DHH.

16.15.4.

Ensure that audit trails be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

16.15.4.1.

Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

16.15.4.2.

Have the date and identification "stamp" displayed on any on-line inquiry;

16.15.4.3.

Have the ability to trace data from the final place of recording back to its source data file and/or document;

16.15.4.4.

Be supported by listings, transaction reports, update reports, transaction logs, or error logs; and

16.15.4.5.

Facilitate auditing of individual records as well as batch audits.

16.15.5.

Have inherent functionality that prevents the alteration of finalized records;

16.15.6.

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

16.15.7.

Restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access;

16.15.8.

Include physical security features designed to safeguard processor sites through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel;

16.15.9.

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

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16.15.10.

Ensure that remote access users of its Systems can only access said Systems through two-factor user authentication and via methods such as Virtual Private Network (VPN), which must be prior approved by DHH no later than fifteen (15) calendar days after the Contract award; and

16.15.11.

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

16.16. Audit Requirements

16.16.1.

The Health Plan shall ensure that their Systems facilitate the auditing of individual claims. Adequate audit trails shall be provided throughout the Systems. To facilitate claims auditing, the Health Plan shall ensure that the Systems follows, at a minimum, the guidelines and objectives of the American Institute of Certified Public Accountants (AICPA) Audit and Account Guide, The Auditor's Study and Evaluation of Internal Control in Electronic Data Processing (EDP) Systems.

16.16.2.

The Health Plan shall maintain and adhere to an internal EDP Policy and Procedures manual available for DHH review upon request, which at a minimum shall contain and assure all accessible screens used throughout the system adhere to the same Graphical User Interface (GUI) standards, and that all programmers shall adhere to the highest industry standards for coding, testing, executing and documenting all system activities. The manual is subject to yearly audit, by both state and independent auditors.

16.17. State Audits

16.17.1.

The Health Plan shall provide to state auditors (including legislative auditors), upon written request, files for any specified accounting period that a valid Contract exists in a file format or audit defined media, magnetic tapes, CD or other media compatible with DHH and/or state auditor's facilities. The Health Plan shall provide information necessary to assist the state auditor in processing or utilizing the files.

16.17.2.

If the auditor's findings point to discrepancies or errors, the Health Plan shall provide a written corrective action plan to DHH within ten (10) business days of receipt of the audit report.

16.17.3.

At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the state auditors. These findings shall be reviewed by DHH and integrated into the Health Plan's EDP manual.

16.18. Independent Audits

16.18.1.

The Health Plan shall be required to contract with an independent firm, subject to the written approval of DHH, which has experience in conducting EDP and compliance audits in accordance with applicable federal and state auditing standards for applications comparable with the scope of the Contract's Systems application. The independent firm shall:

16.18.1.1.

Perform limited scope EDP audits on an ongoing and annual basis for contract compliance at the conclusion of the first twelve (12) month operation period and each twelve (12) month period thereafter, while the Contract is in force with DHH and at the conclusion of the Contract; and

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16.18.1.2.

Perform a comprehensive audit on an annual basis, for controls placed in operation and operation effectiveness, to determine the Health Plan's compliance with the obligations specified in the Contract and the Systems Companion Guide.

16.18.2.

The auditing firm shall deliver to the Health Plan and to DHH a report of findings and recommendations within thirty (30) calendar days of the close of each audit. The report shall be prepared in accordance with generally accepted auditing standards for EDP application reviews.

16.18.3.

DHH shall use the findings and recommendations of each report as part of its monitoring process.

16.18.4.

The Health Plan shall deliver to DHH a corrective action plan to address deficiencies identified during the audit within ten (10) business days of receipt of the audit report. At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the independent auditing firm. These findings are reviewed by DHH and shall become a part of the Health Plan's EDP manual.

16.18.5.

Audits shall include a scope necessary to fully comply with AICPA Professional Standards for Reporting on the Processing of Transactions by Service Organizations (SAS-70 Report).

17. Claims Management

17.1. Electronic Claims Management (ECM) Functionality

17.1.1.

The Health Plan shall annually comply with DHH's Electronic Claims Data Interchange policies for certification of electronically submitted claims.

17.1.2.

To the extent that the Health Plan compensates providers on a FFS or other basis requiring the submission of claims as a condition of payment, the Health Plan shall process the provider's claims for covered services provided to members, consistent with applicable Health Plan policies and procedures and the terms of the Contract and the Systems Companion Guide, including, but not limited to, timely filing, and compliance with all applicable state and federal laws, rules and regulations.

17.1.3.

The Health Plan shall maintain an electronic claims management system that will:

17.1.3.1.

Uniquely identify the attending and billing provider NPI of each service;

17.1.3.2.

Identify the date of receipt of the claim (the date the Health Plan receives the claim and encounter information);

17.1.3.3.

Identify real-time accurate history with dates of adjudication results of each claim such as paid, denied, suspended, appealed, etc., and follow up information on appeals;

17.1.3.4.

Identify the date of payment, the date & number of the check or other form of payment such as electronic funds transfer (EFT);

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17.1.3.5.

Identify all data elements as required by DHH for electronic encounter data submission as stipulated in this Section of the RFP and the Systems Companion Guide; and

17.1.3.6.

Allow submission of non-electronic and electronic claims by contracted providers.

17.1.4.

The Health Plan shall ensure that an electronic claims management (ECM) capability that accepts and processes claims submitted electronically is in place.

17.1.5.

The Health Plan shall ensure the ECM system shall function in accordance with information exchange and data management requirements as specified in this Section of the RFP and the Systems Companion Guide.

17.1.6.

The Health Plan shall ensure that as part of the ECM function it can provide on-line and phone-based capabilities to obtain processing status information.

17.1.7.

The Health Plan shall support access to an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

17.1.8.

The Health Plan shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the Health Plan or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees and/or charges.

17.1.9.

The Health Plan shall require that their providers comply at all times with the American dental Association (ADA) National coding standards (ADA form), and standardized billing forms and formats, and all future updates for Dental and Professional claims (CMS 1500).

17.1.10.

The Health Plan must comply with requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010, regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies implemented as a result of this initiative.

17.1.11.

The Health Plan agrees that at such time that DHH presents recommendations concerning claims billing and processing that are consistent with industry norms, the Health Plan shall comply with said recommendations within ninety (90) calendar days from notice by DHH.

17.1.12.

The Health Plan shall have procedures approved by DHH, available to providers in written and web form for the acceptance of claim submissions which include:

- The process for documenting the date of actual receipt of non-electronic claims and date and time of electronic claims;
- The process for reviewing claims for accuracy and acceptability;
- The process for prevention of loss of such claims, and
- The process for reviewing claims for determination as to whether claims are accepted as clean claims.

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17.1.13.

The Health Plan shall have a procedure approved by DHH available to providers in written and web form for notifying providers of batch rejections. The report, at a minimum, should contain the following information:

- Date batch was received by the Health Plan;
- Date of rejection report;
- Name or identification number of Health Plan issuing batch rejection report;
- Batch submitters name or identification number; and
- Reason batch is rejected.

17.1.14.

The Health Plan shall assume all costs associated with claim processing, including the cost of reprocessing/resubmission, due to processing errors caused by the Health Plan or to the design of systems within the Health Plan's span of control.

17.1.15.

The Health Plan shall not employ off-system or gross adjustments when processing correction to payment error, unless it requests and receives prior written authorization from DHH.

17.1.16.

For purposes of network management, the Health Plan shall notify all contracted providers to file claims associated with covered services directly with the Health Plan, or its contractors, on behalf of Louisiana Medicaid members.

17.1.17.

At a minimum, the Health Plan shall run one (1) provider payment cycle per week, on the same day each week, as determined by the Health Plan and approved by DHH.

17.2. Claims Processing Methodology Requirements

The Health Plan shall perform system edits, including, but not limited to applicable edits as established by DHH policy:

17.2.1.

Confirming eligibility on each member as claims are submitted on the basis of the eligibility information provided by DHH and the FI that applies to the period during which the charges were incurred;

17.2.2.

A review of the entire claim within five (5) working days of receipt of an electronic claim, to determine that the claim is not a clean claim and issue an exception report to the provider indicating all defects or reasons known at that time that the claim is not a clean claim. The exception report shall contain at a minimum the following information:

- Member name;
- Provider claim number, patient account number, or unique member identification number;
- Date of service;
- Total billed charges;
- Health Plan's name; and
- The date the report was generated.

17.2.3.

Medical necessity;

17.2.4.

Prior Approval – The system shall determine whether a covered service required prior approval and if so, whether the Health Plan granted such approval;

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17.2.5.

Duplicate Claims – The system shall in an automated manner, flag a claim as being exactly the same as a previously submitted claim or a possible duplicate and either deny or pend the claim as needed;

17.2.6.

Covered Services - Ensure that the system can verify that a service is a covered service and is eligible for payment;

17.2.7.

Provider Validation - Ensure that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted;

17.2.8.

Quantity of Service - Ensure that the system shall evaluate claims for services provided to members to ensure that any applicable benefit limits are applied;

17.2.9.

Perform system edits for valid dates of service, and assure that dates of services are valid dates such as not in the future or outside of a member's Medicaid eligibility span;

17.2.10.

Perform post-payment review on a sample of claims to ensure services provided were medically necessary; and

17.2.11.

Have a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity.

17.3. Explanation of Benefits

17.3.1.

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

- The service furnished;
- The name of the provider furnishing the service;
- The date on which the service was furnished; and
- The amount of the payment made for the service.

17.3.2.

The Health Plan shall also:

17.3.2.1.

Include in the sample, claims for services with hard benefit limits, denied claims with member responsibility, and paid claims (excluding ancillary and anesthesia services).

17.3.2.2.

Stratify paid claims sample to ensure that all provider types (or specialties) are represented in the pool of generated EOBs. To the extent that the Health Plan considers a particular specialty (or provider) to warrant closer scrutiny, the Health Plan may over sample the group. The paid claims sample should be for a minimum of two hundred (200) to two hundred-fifty (250) claims per year.

17.3.3.

The Health Plan shall track any complaints received from members and resolve the complaints according to its established policies and procedures. The resolution may be member education, provider education, or referral to DHH. The Health Plan shall use the feedback received to modify or enhance the EOB sampling methodology.

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17.4. Remittance Advices

In conjunction with its payment cycles:

17.4.1.

Each remittance advice generated by the Health Plan to a provider shall, if known at that time, clearly identify for each claim, the following information:

17.4.1.1.

The name of the member;

17.4.1.2.

Unique member identification number;

17.4.1.3.

Patient claim number or patient account number;

17.4.1.4.

Date of service;

17.4.1.5.

Total provider charges;

17.4.1.6.

Member liability, specifying any co-insurance, deductible, copayment, or non-covered amount;

17.4.1.7.

Amount paid by the Health Plan;

17.4.1.8.

Amount denied and the reason for denial; and

17.4.1.9.

In accordance with 42 CFR 455.18 and 455.19, the following statement shall be included on each remittance advice sent to providers: "I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws."

17.5. Adherence to Key Claims Management Standards

17.5.1. Prompt Payment to Providers

17.5.1.1.

The Health Plan shall ensure that ninety percent (90%) of all clean claims for payment of services delivered to a member are paid by the Health Plan to the provider within fifteen (15) business days of the receipt of such claims.

17.5.1.2.

The Health Plan shall process and, if appropriate, pay within thirty (30) calendar days, ninety-nine percent (99%) of all clean claims to providers for covered services delivered to a member.

17.5.1.3.

If a clean claim is denied on the basis the provider did not submit required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall not constitute a new claim for purposes of establishing the timeframe for timely filing.

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17.5.1.4.

To the extent that the provider contract requires compensation of a provider on a capitation basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than the time period specified in the provider contract between the provider and the Health Plan, or if a time period is not specified in the contract:

- The tenth (10th) day of the calendar month if the payment is to be made by a contractor, or
- If the Health Plan is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting member roster information from DHH.

17.5.1.5.

The Health Plan shall not deny provider claims on the basis of untimely filing in situations regarding coordination of services or subrogation, in which case the provider is pursuing payment from a third party. In situations of third party benefits, the timeframes for filing a claim shall begin on the date that the third party completes resolution of the claim.

17.5.1.6.

The Health Plan shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or CHIP program pursuant to Section 1128 or 1156 of the Social Security Act or is otherwise not in good standing with DHH.

17.5.2. Claims Dispute Management

17.5.2.1.

The Health Plan shall develop an internal claims dispute process for those claims or group of claims that have been denied or underpaid. The process must be submitted to DHH for approval within thirty (30) days of the date of the Contract is signed, but no later than prior to the Readiness Review, by the Health Plan.

17.5.2.2.

The Claims Dispute process shall allow providers the option to request binding arbitration for claims that have denied or underpaid claims or a group of claims bundled, by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the Health Plan and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this section shall be binding on all parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) days of being selected, unless the Health Plan and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties

17.5.2.3. The Claims Dispute

The Health Plan shall systematically capture the status and resolution of all claim disputes as well as all associated documentation.

17.5.3. Claims Payment Accuracy Report

17.5.3.1.

On a monthly basis, the Health Plan shall submit a claims payment accuracy percentage report to DHH. A copy of the report format and instructions is provided in the Systems Companion Guide. The report shall be based on an audit conducted by the Health Plan. The audit shall be conducted by an entity or staff independent of claims management as specified in this Section of the RFP, and shall utilize a randomly selected sample of all processed and paid claims upon initial submission in each month. A minimum sample consisting of two hundred (200) to two hundred-fifty (250) claims per year, based on financial stratification, shall be selected from the entire population of electronic and paper claims processed or paid upon initial submission.

17.5.3.2.

The minimum attributes to be tested for each claim selected shall include:

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- Claim data correctly entered into the claims processing system;
- Claim is associated with the correct provider;
- Proper authorization was obtained for the service;
- Member eligibility at processing date correctly applied;
- Allowed payment amount agrees with contracted rate;
- Duplicate payment of the same claim has not occurred;
- Denial reason applied appropriately;
- Copayment application considered and applied, if applicable;
- Effect of modifier codes correctly applied; and
- Proper coding.

17.5.3.3.

The results of testing at a minimum should be documented to include:

- Results for each attribute tested for each claim selected;
- Amount of overpayment or underpayment for each claim processed or paid in error;
- Explanation of the erroneous processing for each claim processed or paid in error;
- Determination if the error is the result of a keying error or the result of error in the configuration or table maintenance of the claims processing system; and
- Claims processed or paid in error have been corrected.

17.5.3.4.

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

17.5.4. Encounter Data

17.5.4.1.

The Health Plan's system shall be able to transmit to and receive electronic encounter data from the DHH FI's system as required for the appropriate submission of encounter data.

17.5.4.2.

Within sixty (60) days of operation, the Health Plan's system shall be ready to submit encounter data to the FI in a provider-to-payer-to-payer COB format. The Health Plan must incur all costs associated with certifying HIPAA transactions readiness through a third-party, EDIFECS, prior to submitting encounter data to the FI. Data elements and reporting requirements are provided in the DBP Systems Companion Guide. All encounters shall be submitted electronically in the standard HIPAA transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB Transaction formats (D – Dental, P - Professional, and I - Institutional). Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.

17.5.4.3.

The Health Plan shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided.

17.5.4.4.

The Health Plan shall have the ability to update CDT, CPT/HCPCS, ICD-9-CM, and other codes based on HIPAA standards and move to future versions as required.

17.5.4.5.

In addition to CDT, CPT, ICD-9-CM and other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the Health Plan and DHH to evaluate performance measures.

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17.5.4.6.

The Health Plan will not be permitted to submit paper encounters to DHH's FI. The Health Plan shall have the capability to convert all information that enters its claims system via hard copy paper claims to electronic encounter data, to be submitted in the appropriate HIPAA compliant formats to DHH's FI.

17.5.4.7.

The FI encounter process shall utilize a DHH-approved version of the claims processing system (edits and adjudication) to identify valid and invalid encounter records from an electronic batch submission by the Health Plan. Any submission which contains fatal errors that prevent processing, or that does not satisfy defined threshold error rates, will be rejected and returned to the Health Plan for immediate correction.

17.5.4.8.

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

17.5.4.9.

As specified in the DBP Systems Companion Guide, denials for the following reasons will be of particular interest to DHH:

- Denied for Medical Necessity including lack of documentation to support necessity;
- Member has other insurance that must be billed first;
- Prior authorization not on file;
- Claim submitted after filing deadline; and
- Service not covered by Health Plan.

17.5.4.10.

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

17.5.4.11.

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

17.5.4.12.

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

17.5.4.13.

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

17.5.4.14.

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

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17.5.4.15.

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

17.5.4.16.

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

17.5.4.17.

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

18. Reporting

The Health Plan shall comply with all the reporting requirements established by this Contract. As per 42 CFR 438.242(a)(b)(1)(2) and (3), the Health Plan shall maintain a health information system that collects, analyzes, integrates and reports data that complies with DHH and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and member disenrollment for reasons other than loss of Medicaid eligibility. The Health Plan shall collect data on member and provider characteristics and on services furnished to members.

The Health Plan shall create reports or files (known as Deliverables) using the electronic formats, instructions, and timeframes as specified by DHH and at no cost to DHH. Any changes to the formats must be approved by DHH prior to implementation.

The Health Plan shall provide DHH with a sample of all reports within forty-five (45) calendar days following the date the Contract is signed, but no later than prior to the Readiness Review.

In the event that there are no instances to report, the Health Plan shall submit a report so stating.

As required by 42 CFR 438.604(a) and (b), and 42 CFR 438.606, the Health Plan shall certify all submitted data, documents and reports. The data that must be certified include, but are not limited to, enrollment information, financial reports, encounter data, and other information as specified within the Contract and this RFP. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The Health Plan must submit the certification concurrently with the certified data and documents. DHH will identify specific data that requires certification.

The data shall be certified by one of the following:

- Health Plan's Chief Executive Officer (CEO);
- Health Plan's Chief Financial Officer (CFO); or
- An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

18.1. Ad Hoc Reports

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

18.2. Ownership Disclosure

Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR 455.100-455.104). Form CMS 1513, Ownership and Control Interest Statement, is to be submitted to DHH with the proposal; then resubmitted

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prior to implementation for each Contract period or when any change in the Health Plan's management, ownership or control occurs. The Health Plan shall report any changes in ownership and disclosure information to DHH within thirty (30) calendar days prior to the effective date of the change.

18.3. Information Related to Business Transactions

18.3.1.

The Health Plan shall furnish to DHH or to the HHS, information related to significant business transactions as set forth in 42 CFR 455.105. Failure to comply with this requirement may result in termination of this Contract.

18.3.2.

The Health Plan shall submit, within thirty-five (35) days of a request made by DHH, full and complete information about:

18.3.2.1.

The ownership of any subcontractor with whom the Health Plan has had business transactions totaling more than \$25,000 during the twelve (12) month period ending on the date of this request; and

18.3.2.2.

Any significant business transactions between the Health Plan and any wholly owned supplier or between the Health Plan and any subcontractor, during the five (5) year period ending on the date of this request.

18.3.3.

For the purpose of this Contract, "significant business transactions" means any business transaction or series of transactions during any state fiscal year that exceed the \$25,000 or five (5%) percent of the Health Plan's total operating expenses whichever is greater.

18.3.4. Report of Transactions with Parties in Interest

The Health Plan shall report to DHH all "transactions" with a "party of interest" as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B), as required by Section 1903(m)(4)(A) of the Social Security Act. Federally qualified plans are exempt from this requirement.

a. Definition of Party in Interest – As defined in 1318(b) of the Public Health Service Act, a party in interest is

- i. Any director, officer, partner, or employee responsible for management or administration of a Health Plan any person who is directly or indirectly the beneficial owner of more than 5% of the equity of the Health Plan; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5% of the Health Plan; or, in the case of a Health Plan organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;
- ii. Any organization in which a person described in subsection "i" is director, officer, or partner; has directly or indirectly a beneficial interest of more than 5% of the equity of the Health Plan; or has a mortgage, deed of trust, note, or other interest valuing more than 5% of the assets of the Health Plan;
- iii. Any person directly or indirectly controlling, controlled by, or under common control with a Health Plan or
- iv. Any spouse, child, or parent of an individual described in subsections i, ii, or iii.

b. Types of Transactions Which Must Be Disclosed – Business transactions which must be disclosed include

- i. Any sale, exchange, or lease of any property between the Health Plan and a party in interest;
- ii. Any lending of money or other extension of credit between the Health Plan and the party in interest; and

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iii. Any furnishing for consideration of goods, services (including management services), or facilities between the Health Plan and the party in interest. This does not include salaries paid to employees for services in the normal course of their employment.

c. The information that must be disclosed in the transactions listed in subsection b above between a Health Plan and a party in interest includes

i. The name of the party in interest for each transaction;

ii. A description of each transaction and the quantity or units involved

iii. The accrued dollar value of each transaction during the fiscal year; and

iv. Justification of the reasonableness of each transaction.

d. DHH may require that the information on business transactions be accompanied by a consolidated financial statement for the Health Plan and the party in interest.

e. If the Health Plan has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the Health Plan's business transactions must be reported.

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

18.3.4.1.

Section 1318(b) of the Public Health Service Act defines party of interest as follows:

18.3.4.1.1.

Any director, officer, partner, or employee responsible for management or administration of the Health Plan; any person who is directly or indirectly the beneficial owner of more than 5% of the equity of the Health Plan; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5% of the Health Plan; or, in the case of the Health Plan organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law

18.3.4.1.2.

Any organization in which a person described in the preceding subsection is director, officer or partner; has a direct interest of more than 5% of the equity of the Health Plan; or has a mortgage, deed of trust, note, or other interest valuing more than 5% of the assets of the Health Plan.

18.3.4.1.3.

Any person directly or indirectly controlling, controlled by, or under common control with the Health Plan; or

18.3.4.1.4.

Any spouse, child, or parent of an individual described in the preceding subsections.

18.3.4.2.

Business transactions that must be disclosed include the following:

- Any sale, exchange, or lease of any property between the Health Plan and a party of interest;
- Any lending of money or other extension of credit between the Health Plan and a party of interest;

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- Any furnishing for consideration of goods, services (including management services) or facilities between the Health Plan and the party of interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

18.3.4.3.

Information that must be disclosed for the transactions listed includes the following:

- The name of the party in interest for each transaction;
- A description of each transaction and the quantity or units involved;
- The accrued dollar value of each transaction during the fiscal year; and
- Justification of the reasonableness of the transaction.

18.3.4.4.

DHH may require that the information on business transactions be accompanied by a consolidated financial statement for the Health Plan and the party of interest.

18.3.4.5.

If the Health Plan has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the Health Plan's business transactions must be reported.

18.3.4.6.

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

18.4. Encounter Data

18.4.1.

The Health Plan shall comply with the required format provided by DHH. Encounter data includes claims paid by the Health Plan for services delivered to members through the Health Plan during a specified reporting period. DHH collects and uses this data for many reasons such as: federal reporting, rate setting, risk adjustment, service verification, managed care quality improvement program, utilization patterns and access to care, DHH hospital rate setting and research studies.

18.4.2.

DHH may change the Encounter Data Transaction requirements with thirty (30) calendar days' written notice to the Health Plan. The Health Plan shall, upon notice from DHH, provide notice of changes to subcontractors.

18.5. Information on Persons Convicted of Crimes

The Health Plan shall furnish DHH information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR 455.106. Failure to comply with this requirement may lead to termination of this Contract.

18.6. Errors

18.6.1.

The Health Plan agrees to prepare complete and accurate reports for submission to DHH. If after preparation and submission, a Health Plan error is discovered either by the Health Plan or DHH; the Health Plan shall correct the error(s) and submit accurate reports as follows:

18.6.1.1.

For encounters - In accordance with the timeframes specified in the Administrative Actions, Monetary Penalties and Sanctions Section of this RFP.

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18.6.1.2.

For all reports – Fifteen (15) calendar days from the date of discovery by the Health Plan or date of written notification by DHH (whichever is earlier). DHH may at its discretion extend the due date if an acceptable corrective action plan has been submitted and the Health Plan can demonstrate to DHH's satisfaction the problem cannot be corrected within fifteen (15) calendar days.

18.6.2.

Failure of the Health Plan to respond within the above specified timeframes may result in a loss of any money due the Health Plan and the assessment of monetary penalties as provided in Administration Actions, Monetary Penalties and Sanctions Section of this RFP.

18.7. Report Submission Timeframes

18.7.1.

The Health Plan shall ensure that all required reports or files, as stated in this RFP, are submitted to DHH in a timely manner for review and approval. The Health Plan's failure to submit the reports or files as specified may result in the assessment of monetary penalties, as stated in the Administrative Actions, Monetary Penalties, and Sanctions Section of this RFP.

18.7.2.

Unless otherwise specified, deadlines for submitting files and reports are as follows:

18.7.2.1.

Daily reports and files shall be submitted within one (1) business day following the due date;

18.7.2.2.

Weekly reports and files shall be submitted on the Wednesday following the reporting week;

18.7.2.3.

Monthly reports and files shall be submitted within fifteen (15) calendar days of the end of each month;

18.7.2.4.

Quarterly reports and files shall be submitted by April 30, July 30, October 30, and January 30, for the quarter immediately preceding the due date;

18.7.2.5.

Annual reports and files shall be submitted within thirty (30) calendar days following the twelfth (12th) month; and

18.7.2.6.

Ad Hoc reports shall be submitted within three (3) business days from the agreed upon date of delivery.

18.8. Report Submissions Table

The report submission table below contains a summarized list of reports or files to be submitted by the Health Plan, DHH and the FI. The established format and/or layout requirements for each report or file are located in the Systems Companion Guide, Quality Companion Guide, Appendices of this RFP, or are in development (TBD). Proposers are encouraged to submit samples of existing reports for consideration by DHH for those reports identified in the report chart as TBD.

Report Submissions Table

Submitter	Report or File Name	Frequency	Format Location	Receiver
Health Plan	Organizational Chart	Annually and Upon Request	NA	DHH – Bayou Health
Health Plan	Functional Organizational Chart	Annually and Upon Request	NA	DHH – Bayou Health

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Health Plan	DBP Network Provider and Subcontractor Registry	At Readiness Review and Monthly thereafter	Appendix V	DHH – Bayou Health
DHH – Bayou Health	Readiness Review Report	As Appropriate	TBD	Health Plan
Health Plan	Provider Directory	Template due during Readiness Review	TBD	DHH – Bayou Health
Health Plan	New Member Contact Report	A. Monthly B. Monthly with an Annual Summary	TBD	DHH – Bayou Health
Health Plan	Provider Call Center	Monthly with an Annual Summary	TBD	DHH – Bayou Health
Health Plan	Referral Policies	During Readiness Review, Annually thereafter, and prior to any revisions	TBD	DHH – Bayou Health
Health Plan	Non-Medicaid Enrolled Providers	Monthly	Submitted via the Provider Registry as described in the Systems Companion Guide	DHH – FI
Health Plan	Member Disenrollment File	Daily	Systems Companion Guide TBD	DHH – FI
Health Plan	Health Plan Disenrollment Report	Quarterly	Appendix W	DHH – Bayou Health
DHH – FI	Health Plan PMPM Reconciliation File	Monthly	Systems Companion Guide TBD	Health Plan
Health Plan	EPSDT Report (CMS 416)	Quarterly and Annually, due March 31 (6 months after the end of the FFY)	Appendix X	Quarterly DHH – Bayou Health Annual - FI
Health Plan	Medical Record Review	During Readiness Review, and Annually thereafter	TBD	DHH – Bayou Health
Health Plan	Service Area Review of Appointment Availability /Twenty-four (24) hour Access and Availability Survey	Annually	Instrument and Survey Results	DHH – Bayou Health
Health Plan	UM reports A. UM Committee Meeting minutes B. Medical Record Reviews	A. Within 5 working days of each meeting B. Quarterly with an Annual Summary	TBD	DHH – Bayou Health
Health Plan	Fraud and Abuse Activity Report	Quarterly with an Annual Summary	TBD	DHH – Bayou Health
Health Plan	Model Attestation Letter	Attachment to all Reports	Appendix Y	DHH – Bayou Health
Health Plan	Form CMS 1513 Ownership and Control Interest Statement	With proposal and Annually, by October 1st, thereafter	NA	DHH – Bayou Health
Health Plan	Emergency Management Plan	During readiness review, 30 days prior to proposed changes, Annual certification	NA	DHH – Bayou Health
Health Plan	Member Satisfaction Survey Report	Annually	Instrument and Survey Results	DHH – Bayou Health
Health Plan	Provider Satisfaction Survey Report	Annually	Instrument and Survey Results	DHH – Bayou Health

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Health Plan	Network Provider Development and Management Plan	During readiness review and Annually thereafter or as requested by DHH	TBD	DHH – Bayou Health
Health Plan	Grievance, Appeal and Fair Hearing Log Report	Monthly, and Quarterly Summary	Appendix S	DHH – Bayou Health
Health Plan	Grievance, Appeal and Fair Hearing Log - Redacted	Monthly, and Quarterly Summary	Appendix S	DHH – Bayou Health
Health Plan	Marketing Activities A. Marketing Plan B. Updates C. Annual Review	A. Due at Readiness Review B. Monthly C. Annually	Appendix R	DHH – Bayou Health
Health Plan	Third Party Liability Collections	Annually	Systems Companion Guide TBD	DHH
Health Plan	Claims Payment Accuracy Report	Monthly	Systems Companion Guide TBD	DHH – FI
Health Plan	Claims Processing Interest Payments	Quarterly	TBD	DHH – Bayou Health
Health Plan	Annual Medical Loss Ratio Report	Beginning second CY of implementation Due June 1 for previous CY	TBD	DHH – Bayou Health
Health Plan	Financial Reporting	A. Annual Audited Financial Statement B. Four Quarterly Unaudited Financial Statements and Financial Reporting Guide C. Monthly if requested by DHH	Financial Reporting Companion Guide	DHH – Bayou Health
Health Plan	Encounter Submission File	Weekly	Systems Companion Guide	DHH – FI
DHH – FI	Encounter Claims Summary File	Weekly	Systems Companion Guide	Health Plan
DHH – FI	Encounter Edit Disposition Summary File	Weekly	Systems Companion Guide	Health Plan
DHH – FI	Edit Code Detail File	Weekly	Systems Companion Guide	Health Plan
Health Plan	Denied Claims Report	Weekly	Systems Companion Guide	DHH – Bayou Health
Health Plan	FQHC/RHC Encounter File	Weekly	Systems Companion Guide TBD	DHH – Bayou Health

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Health Plan	<p>Quality Assurance (QA)</p> <p>A. QAPI Program description and QAPI Plan</p> <p>B. Impact and effectiveness of QAPI program evaluation</p> <p>C. Performance Improvement Project descriptions</p> <p>D. Performance Improvement Projects Outcomes</p> <p>E. Early Warning System Performance Measures</p> <p>F. Level I and Level II Performance Measures</p> <p>G. Primary Care Dentist Profile Reports</p>	<p>A. During readiness review, and Annually thereafter</p> <p>B. Annually</p> <p>C. Within 3 months of execution of Contract and at the beginning of each Contract year thereafter</p> <p>D. Annually</p> <p>E. Monthly</p> <p>F. Annually and upon DHH request</p> <p>G. Quarterly with an Annual Summary</p>	Quality Companion Guide	DHH – Bayou Health
Health Plan	System Refresh Plan	Annually	Systems Companion Guide TBD	DHH – Bayou Health
Health Plan	Back-up File List	Quarterly	Systems Companion Guide TBD	DHH – Bayou Health
Health Plan	Electronic Data Processing (EDP) Audit	Annually	TBD	DHH – Bayou Health
DHH – FI	Claims Historical Data and Immunization Data	At onset of implementation and Monthly thereafter	Systems Companion Guide TBD	Health Plan
Health Plan	Case Management Reports	Quarterly with an Annual Summary	TBD	DHH – Bayou Health
Health Plan	Prior Authorization and Pre-Certification Summary	Annually	Systems Companion Guide TBD	DHH – Bayou Health
Health Plan	SAS 70 Report	Annually	NA	DHH – Bayou Health
Health Plan	Member Advisory Council Plan	Annually with Quarterly updates of meeting minutes and correspondence	NA	DHH – Bayou Health
Health Plan	Insure Kids Now	Annual Summary of Benefits and Quarterly Provider Data	TBD	DHH-Bayou Health

19. Contract Compliance and Monitoring

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

19.1. Contact Personnel

19.1.1. Liaisons

The Health Plan shall designate an employee of its administrative staff to act as the liaison between the Health Plan and DHH for the duration of the Contract. Bayou Health will be the Health Plan's point of contact and shall receive all inquiries and requests for interpretation regarding the Contract and all required reports unless otherwise specified in the Contract. The Health Plan shall also designate a member of its senior management who shall act as a liaison between the Health Plan's senior management and DHH when such communication is required. If different representatives are designated after

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approval of the Contract, notice of the new representative shall be provided in writing within seven (7) calendar days of the designation.

19.1.2. Contract Monitor

All work performed by the Health Plan will be monitored by the Contract Monitor:

Department of Health and Hospitals
Bureau of Health Services Financing
Bayou Health Program
628 North 4th St.
Baton Rouge, LA 70821
Phone: TBD
Email: TBD

19.2. Notices

Any notice given to a party under the Contract is deemed effective, if addressed to the party as addressed below, upon: (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by facsimile if a copy of the notice is sent by another means specified in this Section; (iii) the third Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

DHH
Name: TBD
Bayou Health
628 North 4th St.
Baton Rouge, LA 70821
Contractor
Name TBD
Address TBD

Either party may change its address for notification purposes by providing written notice stating the change, effective date of change and setting forth the new address at least 10 calendar days prior to the effective date of the change of address. If different representatives are designated after execution of the Contract, notice of the new representative will be given in writing to the other party and attached to originals of the Contract.

Whenever DHH is required by the terms of this RFP to provide written notice to the Health Plan, such notice will be signed by the Medicaid Director or his/her designee

19.3. Notification of Health Plan Policies and Procedures

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

19.4. Required Submissions

Within thirty (30) calendar days from the date the Contract is signed by the Health Plan, but prior to the Readiness Review, the Health Plan shall submit documents as specified in this RFP. DHH shall have the right to approve, disapprove or require modification of these documents and any procedures, policies and materials related to the Health Plan's responsibilities under the terms of the Contract. Refer to Appendix Z, Transition Requirements for a listing of submission requirements.

19.5. Readiness Review Prior to Operations Start Date

DHH will assess the performance of the Health Plan prior to and after the March 1, 2013 begin date for operations. DHH will complete readiness reviews of the Health Plan prior to implementation. This includes evaluation of the Health Plan's program components including IT, administrative services and medical management. Each readiness review will be performed on site at the Health Plan's Louisiana administrative offices. Refer to Appendix Z, Transition Period Requirements.

19.6. Ongoing Contract Monitoring

DHH will monitor the Health Plan's performance to assure the Health Plan is in compliance with the Contract provisions. However this does not relieve the Health Plan of its responsibility to continuously monitor its providers' performance in compliance with the Contract provisions.

19.6.1.

DHH or its designee shall coordinate with the Health Plan to establish the scope of review, the review site, relevant time frames for obtaining information, and the criteria for review.

19.6.2.

DHH or its designee will, at a minimum annually, monitor the operation of the Health Plan for compliance with the provisions of this Contract, and applicable federal and state laws and regulations. Inspection may include the Health Plan's facilities, as well as auditing and/or review of all records developed under this Contract including, but not limited to, periodic medical audits, grievances, enrollments, disenrollment, utilization and financial records, review of the management systems and procedures developed under this Contract and any other areas or materials relevant or pertaining to this Contract.

19.6.3.

The Health Plan shall provide access to documentation, medical records, premises, and staff as deemed necessary by DHH.

19.6.4.

The Health Plan shall have the right to review and comment on any of the findings and recommendations resulting from Contract monitoring and audits, except in the cases of fraud investigations or criminal action. However, once DHH finalizes the results of monitoring and/or audit report, the Health Plan must comply with all recommendations resulting from the review. Failure to comply with recommendations for improvement may result in monetary penalties, sanctions and/or enrollment restrictions.

19.7. Health Plan On-Site Reviews

DHH will conduct on-site readiness reviews prior to member enrollment during initial implementation of the DBP and as an ongoing activity during the Contract period. The Health Plan's on-site review will include a desk audit and on-site focus component. The site review will focus on specific areas of Health Plan performance. These focus areas may include, but are not limited to the following

- Administrative capabilities
- Governing body
- Subcontracts
- Provider network capacity and services
- Provider Complaints
- Member services
- Primary care dentist assignments and changes
- Member grievances and appeals
- Health education and promotion
- Quality improvement
- Utilization review
- Data reporting
- Coordination of care
- Claims processing
- Fraud and abuse

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19.8. Monitoring Reports

DHH will require the Health Plan to submit monthly, quarterly, and annual reports that will allow DHH to assess the Health Plan's performance.

19.9. Corrective Action

When DHH establishes that the Health Plan is out of compliance with any of the above monitored activities, the Health Plan will be required to provide corrective action plans to ensure that the goals of the program will be met. DHH may levy penalties commensurate with the offense at its discretion.

20. Administrative Actions, Monetary Penalties, and Sanctions

20.1. Administrative Actions

20.1.1.

DHH shall notify the Health Plan through a written Notice of Action when it is determined the Health Plan is deficient or non-compliant with requirements of the Contract. Administrative actions exclude monetary penalties, intermediate actions and termination and include, but are not limited to:

20.1.1.1.

A warning through written notice or consultation;

20.1.1.2.

Education requirement regarding program policies and billing procedures; The Health Plan may be required by DHH to participate in a provider education program as a condition of continued participation. Health Plan education programs may include a letter of warning or clarification on the use and format of provider manuals; instruction on the use of procedure codes; review of key provisions of the Medicaid Program; instruction on reimbursement rates; instructions on how to inquire about coding or billing problems; and quality/medical issues;

20.1.1.3.

Review of prior authorization implementation processes;

20.1.1.4.

Referral to the Louisiana Department of Insurance for investigation;

20.1.1.5.

Referral for review by appropriate professional organizations;

20.1.1.6.

Referral to the Office of the Attorney General for fraud investigation; and/or

20.1.1.7.

Require submission of a corrective action plan.

20.2. Corrective Action Plan

If DHH determines the Health Plan is out of compliance or if DHH determines a CAP is required, the Health Plan shall:

20.2.1.1.

Submit a CAP, within thirty (30) calendar days of the date of notification or as specified by DHH, for the deficiencies identified by DHH.

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20.2.1.2.

Within thirty (30) calendar days of receiving the CAP, DHH will either approve or disapprove the CAP. If disapproved, the Health Plan shall resubmit, within fourteen (14) calendar days, a new CAP that addresses the deficiencies identified by DHH.

20.2.1.3.

Upon approval of the CAP, whether the initial CAP or the revised CAP, the Health Plan shall implement the CAP within the time frames specified by DHH.

20.2.1.4.

If the initial or revised CAP is disapproved DHH may levy penalties and/or sanctions pending attainment of acceptable CAP commensurate with the offense at its discretion.

20.2.1.5.

If the initial or revised CAP performance/outcomes are not achieved DHH may levy penalties and/or sanctions pending attainment of acceptable performance or outcome commensurate with the offense at its discretion.

20.2.1.6.

DHH may require a corrective action plan, , to be developed and approved by DHH in situations where intermediate sanctions may be imposed. DHH shall approve and monitor implementation of such a plan and set appropriate timelines to bring activities of the Health Plan into compliance with state and federal regulations. DHH may monitor via required reporting on a specified basis and/or through on-site evaluations, the effectiveness of the plan. Before imposing intermediate sanctions, DHH shall give the Health Plan timely written notice that explains the basis and nature of the sanction and any other due process protections that DHH elects to provide and shall provide notification to CMS.

20.2.1.7.

Whenever monetary penalties for a single occurrence exceed \$25,000.00, DHH staff will meet with Health Plan staff to discuss the causes for the occurrence and to negotiate a reasonable plan for corrective action of the occurrence. Once a corrective action plan has been approved by DHH, collection of monetary penalties during the agreed upon corrective action period will be suspended. The corrective action plan must include a date certain for the correction of the occurrence. Should that date for correction be missed by the Health Plan, the original schedule of monetary penalties will be reinstated, including collection of monetary penalties for the corrective action period, and monetary penalties will continue until satisfactory correction as determined by DHH of the occurrence has been made.

20.3. Monetary Penalties

20.3.1.

The purpose of establishing and imposing monetary penalties is to provide a means for DHH to obtain the services and level of performance required for successful operation of the Contract. DHH's failure to assess monetary penalties in one or more of the particular instances described herein will in no event waive the right for DHH to assess additional monetary penalties or actual damages.

20.3.2.

The decision to impose monetary penalties shall include consideration of the following factors:

- The duration of the violation;
- Whether the violation (or one that is substantially similar) has previously occurred;
- The Health Plan's history of compliance;
- The severity of the violation and whether it imposes an immediate threat to the health or safety of the Medicaid members; and
- The "good faith" exercised by the Health Plan in attempting to stay in compliance.

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20.3.3.

For purposes of this section, violations including individual, unrelated enrollees shall not be considered as arising out of the same action.

Monetary Penalties Table

Failed Deliverable	Sanction
Operations Start Date	Ten thousand dollars (\$10,000.00) per calendar day for each day beyond the Operations Start Date that the Health Plan is not operational until the day that the Health Plan is operational, including all systems.
Operations Readiness	Final versions of the Provider Directory must be submitted no later than 7 days prior to the Operational Start Date. One thousand (\$1,000.00) per calendar day for each day the directory is late, inaccurate or incomplete.
System Readiness Review <ul style="list-style-type: none"> • Disaster Recovery Plan • Business Continuity Plan • Systems Quality Assurance Plan 	Health Plan must submit to DHH or the Readiness Review Contractor the subject plans no later than 120 days prior to Operational Start Date. One thousand (\$1,000.00) per calendar day for each day a deliverable is late, inaccurate, or incomplete.
Encounter Data	<p>Ten thousand dollars (\$10,000.00) per calendar day for each day after the due date that the monthly encounter data has not been received in the format and per specifications outlined in the RFP.</p> <p>Ten thousand dollars (\$10,000.00) per calendar day for each day encounter data is received after the due date, for failure to correct and resubmit encounter data that was originally returned to the Health Plan for correction because submission data was in excess of the five (5) percent error rate threshold, until acceptance of the data by the fiscal intermediary.</p> <p>Ten thousand dollars (\$10,000.00) per return by the fiscal intermediary of re-submission of encounter data that was returned to the Health Plan, as submission data was in excess of the five (5) percent error rate threshold, for correction and was rejected for the second time.</p> <p>Ten thousand dollars (\$10,000.00) per occurrence of medical record review by DHH or its designee where the Health Plan or its provider(s) denotes provision of services which were not submitted in the encounter data regardless of whether or not the provider was paid for the service that was documented.</p> <p>Penalties specified above shall not apply for encounter data for the first three months after direct services to Health Plan members have begun to permit time for development and implementation of a system for exchanging data and training of staff and healthcare providers.</p>
Prompt Pay Ninety percent (90%) of all clean claims must be paid within fifteen (15) business days of the date of receipt.	Five thousand dollars (\$5,000.00) for the first quarter that the Health Plan's claims performance percentages by claim type fall below the performance standard.

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<p>Ninety-nine percent (99%) of all clean claims must be paid within thirty (30) calendar days of the date of receipt.</p> <p>The Health Plan shall pay providers interest at 12% per annum, calculated daily for the full period in which the clean claim remains unadjudicated beyond the 30-day claims processing deadline. Interest owed the provider must be paid the same date that the claim is adjudicated.</p>	<p>Twenty-five thousand dollars (\$25,000.00) per quarter for each additional quarter that the claims performance percentages by claim type fall below the performance standards.</p> <p>One thousand dollars (\$1,000.00) per claim if the Health Plan fails to timely pay interest.</p>
<p style="text-align: center;">Claims Summary Report</p>	<p>One thousand dollars (\$1,000.00) per calendar day the report is late, inaccurate, or incomplete.</p>
<p style="text-align: center;">Quality Assessment and Performance Improvement Reports</p>	<p>Two thousand dollars (\$2,000.00) per report for each calendar day the Quality Assessment and Performance Improvement Plan (QAPI), performance measure, and/or performance improvement project reports are late or incorrect as outlined in this RFP and the Quality Companion Guide.</p>
<p style="text-align: center;">Member and/or Provider Satisfaction Report(s)</p>	<p>Two thousand dollars (\$2,000.00) per calendar day for each calendar day the report(s) are late or incorrect.</p>
<p style="text-align: center;">Member Services Activities</p>	<p>Five thousand dollars (\$5,000.00) per calendar day for failure to provide access to primary care dentists that offer extended office hours as defined by the RFP.</p> <p>Five thousand dollars (\$5,000.00) per calendar day for failure to provide member services functions from 7 a.m. to 7 p.m. Central Time, Monday through Friday, to address non-emergency issues encountered by members, and 24 hours a day, 7 days a week to address emergency issues encountered by members.</p> <p>Five thousand dollars (\$5,000.00) per calendar day for failure to operate a toll-free hotline that members can call 24 hours a day, seven (7) days a week.</p>
<p style="text-align: center;">Member Call Center</p> <ul style="list-style-type: none"> • Answer 90% of calls within 30 seconds • Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of calls of not more than 5% 	<p>One hundred dollars (\$100.00) for each percentage point for each standard that fails to meet the requirements for a monthly reporting period.</p> <p>One hundred dollars (\$100.00) for each 30 second time increment, or portion thereof, by which the Health Plan's average hold time exceeds the maximum acceptable hold time.</p>
<p style="text-align: center;">Administrative Service</p>	<p>Failure which results in actual harm to a member, places a member at risk of imminent harm, or materially affects DHH's ability to administer the Program.</p> <p>Five thousand dollars (\$5,000.00) per calendar day for each incident of non-compliance per Geographic Service Area (GSA).</p>
<p style="text-align: center;">Provider Demographics</p>	<p>Five thousand dollars (\$5,000.00) per calendar day for failure to provide and validate provider demographic data on a quarterly basis to ensure current, accurate, and clean data is</p>

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	on file for all contracted providers.
Provider Service Activities	<p>Five thousand dollars (\$5,000.00) per calendar day for failure to provide for arrangements to handle emergent provider issues on a twenty-four (24) hour, seven (7) days-a-week basis.</p> <p>Five thousand dollars (\$5,000.00) per calendar day for failure to furnish provider services functions from 7 a.m. to 5 p.m. Central Time, Monday through Friday to address non-emergency issues encountered by providers.</p>
<p>Provider Call Center</p> <ul style="list-style-type: none"> • Answer 95% of calls within 30 seconds • Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of calls of not more than 5% 	<p>One hundred dollars (\$100.00) for each percentage point for each standard that fails to meet the requirements for a monthly reporting period.</p> <p>One hundred dollars (\$100.00) for each thirty (30) second time increment, or portion thereof, by which the Health Plan's average hold time exceeds the maximum acceptable hold time.</p>
Covered Services	<p>Failure to provide a Health Plan covered service that is not otherwise associated with a performance standard and such failure results in actual harm to a member or places a member at risk of imminent harm.</p> <p>Seventy-five hundred dollars (\$7,500.00) per calendar day for each incident of non-compliance.</p>
Management Information System	<p>In the event of a declared major failure or disaster, the Health Plan's core eligibility, enrollment, and claims processing system shall be back on line within seventy-two (72) hours of the failure or disaster's occurrence.</p> <p>Five thousand dollars (\$5,000.00) per calendar day of non-compliance per GSA.</p>
Transfer of Data	<p>The Health Plan must transfer all data regarding the provision of covered services to members to DHH, at the sole discretion of DHH and as directed by DHH. Ten thousand dollars (\$10,000.00) per calendar day that the data is late, inaccurate or incomplete.</p>
Termination Transition Plan	<p>Six months prior to the end of the Contract period or any extension thereof or if earlier, within thirty (30) days of Notice of Termination</p> <p>One thousand dollars (\$1,000.00) per calendar day the plan is late, inaccurate, or incomplete.</p>
Ad Hoc Reports as required by this Contract or upon request by DHH.	<p>Two thousand dollars (\$2,000.00) per calendar day for each business day that a report is late or incorrect.</p>

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Member File Updates	Failure to upload all Member File updates prior to end of month reconciliation process with files submitted to the Health Plan by the FI. Five thousand dollars (\$5,000.00) for each occurrence of non-compliance.
Corrective Action Plan	Two thousand dollars (\$2,000.00) per each calendar day the CAP is late or incorrect.
Network Adequacy	Ten thousand dollars (\$10,000) per occurrence the Health Plan has not meet the network adequacy requirements outlined in this RFP.
Access Standards and Guidelines, Timeliness	One thousand dollars (\$1,000) per occurrence the Health Plan is not in compliance with Sections 7.3 through 7.5 of this RFP.
Covered Services	Five thousand dollars (\$5,000) per occurrence if a Health Plan provider refuses to provide services without timely notifying recipients or making alternative arrangements. One thousand dollars (\$1,000) plus the cost of the service for a member in which the Health Plan was asked to provide the service by DHH and refused to provide the core benefit or service(s).

20.3.4.

DHH shall utilize the following guidelines to determine whether a report is correct and complete:

- The report must contain 100% of the Health Plan’s data; and
- 99% of the required items for the report must be completed; and
- 99.5% of the data for the report must be accurate as determined by edit specifications/review guidelines set forth by DHH.

20.4. Other Reporting and/or Deliverable Requirements

20.4.1.

For each day that a deliverable is late, incorrect or deficient, the Health Plan may be liable to DHH for monetary penalties in an amount per calendar day per deliverable as specified in the table below for reports and deliverables not otherwise specified in the above Table of Monetary Penalties, or requirement/activity of noncompliance.

20.4.2.

Monetary penalties have been designed to escalate by duration and by occurrence over the term of this Contract, inclusive of any contract extensions.

Monetary Penalties Escalation Table

Occurrence	Daily Amount for Days 1 - 14	Daily Amount for Days 15-30	Daily Amount for Days 31-60	Daily Amount for Days 61 and Beyond
1-3	\$750	\$1,200	\$2,000	\$3,000
4-6	\$1,000	\$1,500	\$3,000	\$5,000
7-9	\$1,500	\$2,000	\$4,000	\$6,000
10-12	\$1,750	\$3,500	\$5,000	\$7,500
13 and beyond	\$2,000	\$4,000	\$7,500	\$10,000

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20.5. Employment of Key and Licensed Personnel

20.5.1.

Seven hundred dollars (\$700.00) per calendar day for failure to have a full-time acting or permanent Administrator/CEO for more than seven (7) consecutive calendar days for each day the Administrator/CEO has not been appointed;

20.5.2.

Seven hundred dollars (\$700.00) per calendar day for failure to have a full-time acting or permanent Dental Director for more than seven (7) consecutive calendar days for each day the Dental Director has not been appointed.

20.5.3.

Two hundred fifty dollars (\$250.00) per calendar day for each day that personnel are not licensed as required by applicable state and federal laws and/or regulations.

20.6. Excessive Reversals on Appeal

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

20.7. Marketing and Member Education Violations

20.7.1.

Whenever DHH determines that the Health Plan its agents, subcontractors, volunteers or providers has engaged in any unfair, deceptive, or prohibited marketing or member education practices in connection with proposing, offering, selling, soliciting, and providing any healthcare services, one or more of the remedial actions listed below shall apply.

20.7.2.

Unfair, deceptive, or prohibited marketing practices shall include, but is not limited to:

20.7.2.1.

Failure to secure written approval before distributing marketing or member education materials;

20.7.2.2.

Engaging in, encouraging or facilitating prohibited marketing by a provider;

20.7.2.3.

Directly marketing to enrollees or potential enrollees;

20.7.2.4.

Failure to meet time requirements for communication with new members (distribution of welcome packets, welcome calls);

20.7.2.5.

Failure to provide interpretation services or make materials available in required languages.

20.7.2.6.

Engaging in any of the prohibited marketing and member education practices detailed in this RFP;

20.7.2.7.

False, misleading oral or written statement, visual description, advertisement, or other representation of any kind which has the capacity, tendency, or effect of deceiving or misleading Health Plan potential enrollees or enrollees with respect to any healthcare services, Health Plan or healthcare provider; or Bayou Health;

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20.7.2.8.

Representation that the Health Plan or network provider offers any service, benefit, access to care, or choice which it does not have;

20.7.2.9.

Representation that the Health Plan or healthcare provider has any status, certification, qualification, sponsorship, affiliation, or licensure which it does not have;

20.7.2.10.

Failure to state a material fact if the failure deceives or tends to deceive;

20.7.2.11.

Offering any kickback, bribe, award, or benefit to any Medicaid eligible as an inducement to select, or to refrain from selecting any healthcare service, Health Plan, or healthcare provider, unless the benefit offered is medically necessary healthcare; and

20.7.2.12.

Use of the Medicaid eligible's or another person's information which is confidential, privileged, or which cannot be disclosed to or obtained by the user without violating a state or federal confidentiality law, including:

- Medical records information, and
- Information which identifies the recipient or any member of his or her group as a recipient of any government sponsored or mandated health coverage program; and

20.7.2.13.

Use of any device or artifice in advertising the Health Plan or soliciting a Medicaid eligible which misrepresents the solicitor's profession, status, affiliation, or mission.

20.7.3.

In order to ensure that members have access to a broad range of healthcare providers, and to limit the potential for disenrollment due to lack of access to providers or services, the Health Plan shall not have a contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another Health Plan or in which the Health Plan represents or agrees that it will not contract with another provider. The Health Plan shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.

If DHH determines the Health Plan or its subcontractors has steered potential members to join the Health Plan, DHH may impose the following sanctions:

- a. The member(s) shall be disenrolled from the Health Plan at the earliest effective date allowed;
- b. PMPMs for the months(s) the member(s) was enrolled in the Health Plan will be recouped;
- c. The Health Plan shall be assessed an additional \$5,000 monetary sanction per member; and
- d. The Health Plan shall submit a letter to each member notifying the member of their imposed sanction and of their right to choose another Health Plan.

20.7.4.

If DHH determines the Health Plan has violated any of the marketing and/or outreach activities outlined in the Contract, the Health Plan may be subject to remedial sanctions specified in Section 20.8 and/or a monetary sanction of up to \$10,000 per violation/incident. The amount and type of sanctions shall be at the sole discretion of DHH.

20.8. Remedial Action(s) for Marketing Violations

DHH shall notify the Health Plan in writing of the determination of the non-compliance, of the remedial action(s) that must be taken, and of any other conditions related such as the length of time the remedial actions shall continue and of the corrective actions that the Health Plan must perform.

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20.8.1.

DHH may require the Health Plan to recall the previously authorized marketing material(s);

20.8.2.

DHH may suspend enrollment of new members to the Health Plan;

20.8.3.

DHH may deduct the amount of capitation payment for members enrolled as a result of non-compliant marketing practices from the next monthly capitation payment made to the Health Plan and shall continue to deduct such payment until correction of the failure;

20.8.4.

DHH may require the Health Plan to contact each member who enrolled during the period while the Health Plan was out of compliance, in order to explain the nature of the non-compliance; or

20.8.5.

DHH may prohibit future marketing activities by the Health Plan for an amount of time specified by DHH.

20.9. Cost Avoidance Requirements

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

20.10. Failure to Provide Core Benefits and Services

In the event that DHH determines that the Health Plan failed to provide one or more core benefits and services, DHH shall direct the Health Plan to provide such service. If the Health Plan continues to refuse to provide the core benefit or service(s), DHH shall authorize the members to obtain the covered service from another source and shall notify the Health Plan in writing that the Health Plan shall be charged the actual amount of the cost of such service. In such event, the charges to the Health Plan shall be obtained by DHH in the form of deductions of that amount from the next monthly capitation payment made to the Health Plan. With such deductions, DHH shall provide a list of the members from whom payments were deducted, the nature of the service(s) denied, and payments DHH made or will make to provide the medically necessary covered services.

20.11. Failure to Maintain an Adequate Network of Contract Providers

In the event that DHH determines that the Health Plan 1) failed to maintain an adequate network of mandatory contract provider types as specified in Section 7 of this RFP, 2) did not comply with the requirement to make three documented attempts to contract with the provider, and 3) is required to pay for medically necessary services to a non-network provider, a monetary penalty of up to \$10,000 per incident may be assessed.

20.12. Intermediate Sanctions

20.12.1.

DHH shall notify the Health Plan and CMS in writing of its intent to impose sanctions for violating the terms and conditions of the Contract or violation of federal Medicaid rules and regulations and will explain the process for the Health Plan to employ the dispute resolution process as described in this RFP. The following are non-exhaustive grounds for which intermediate sanctions may be imposed when the Health Plan acts or fails to act. The Health Plan:

20.12.1.1.

Fails substantially to provide medically necessary services that the Health Plan is required to provide, under law or under the Contract, to a member covered under the Contract;

20.12.1.2.

Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Louisiana Medicaid DBP;

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20.12.1.3.

Acts to discriminate among members on the basis of their health status or need for healthcare services; this includes termination of enrollment or refusal to reenroll a member or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future medical services.

20.12.1.4.

Misrepresents or falsifies information that it furnishes to CMS or to DHH;

20.12.1.5.

Misrepresents or falsifies information that it furnishes to a member, potential member, or a healthcare provider;

20.12.1.6.

Fails to comply with the requirements for Provider Incentive Plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210;

20.12.1.7.

Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by DHH or that contain false or materially misleading information; or

20.12.1.8.

Violates any of the other applicable requirements of Section 1903(m), 1905(t)(3) or 1932 of the Social Security Act and any implementing regulations.

20.12.2.

The intermediate sanctions that DHH may impose upon the Health Plan shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u-2) and 42 CFR 438.700-730 and may include any of the following:

20.12.2.1.

Civil monetary penalties in the following specified amounts:

- A maximum of \$25,000 for each determination of failure to provide services; misrepresentation or falsification of statements to members, potential members, or healthcare providers; failure to comply with Provider Incentive Plan requirements; or marketing violations;
- A maximum of \$100,000 for each determination of discrimination among members on the basis of their health status or need for services; or misrepresentation or falsification to CMS or DHH;
- A maximum of \$15,000 for each member DHH determines was discriminated against based on the member's health status or need for services (subject to the \$100,000 limit above);
- A maximum of \$25,000 or double the amount of the excess charges (whichever is greater), for charging premiums or charges in excess of the amounts permitted under the Louisiana Medicaid DBP Program. DHH shall return the amount of overcharge to the affected member(s);

20.12.2.2.

Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll;

20.12.2.3.

Suspension of all new enrollments, including automatic assignment, after the effective date of the sanction;

20.12.2.4.

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

20.12.2.5.

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

20.12.3.

The following factors will be considered in determining sanction(s) to be imposed:

- Seriousness of the offense(s);
- Patient quality of care issues;
- Failure to perform administrative functions;
- Extent of violations; history of prior violations; prior imposition of sanctions;
- Prior provision of provider education; provider willingness to obey program rules;
- Whether a lesser sanction will be sufficient to remedy the problem; and
- Actions taken or recommended by peer review groups or licensing boards.

20.13. Suspension of Enrollment

If DHH determines that the Health Plan is out of compliance with the Contract, DHH may suspend the Health Plan's enrollment of new members under the Contract. DHH, when exercising this option, will notify the Health Plan in writing of its intent to suspend new enrollment prior to the beginning of the suspension period. The suspension period may be for any length of time specified by DHH. DHH will submit a Notice of Suspension of Enrollment no less than five (5) calendar days previous to initiation of the suspension. The Louisiana Medicaid Director may require the provider to correct any deficiencies which served as the basis for the suspension as a condition of reinstatement of enrollment activities.

20.14. Misconduct for Which Intermediate Sanctions May Be Imposed

20.14.1.

DHH may impose sanctions against the Health Plan if the agency finds any of the following non-exclusive actions/occurrences:

20.14.1.1.

The Health Plan has failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from DHH;

20.14.1.2.

The Health Plan has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to Public Law 95-142;

20.14.1.3.

The Health Plan or any of its owners, officers or directors has been convicted of a criminal offense relating to performance of the Contract with DHH or of fraudulent billing practices or of negligent practice resulting in death or injury to the Health Plan's member;

20.14.1.4.

The Health Plan has presented, or has caused to be presented, any false or fraudulent claim for services or has submitted or has caused to be submitted false information to be furnished to the state or the Secretary of the federal Department of Health and Human Services;

20.14.1.5.

The Health Plan has engaged in a practice of charging and accepting payment (in whole or part) from members for services for which a PMPM payment was made by DHH;

20.14.1.6.

The Health Plan has rebated or accepted a fee or portion of fee or charge for a patient referral;

20.14.1.7.

The Health Plan has failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments;

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20.14.1.8.

The Health Plan has failed to keep or make available for inspection, audit or copying, such records regarding payments claimed for providing services;

20.14.1.9.

The Health Plan has failed to furnish any information requested by DHH regarding payments for providing goods or services;

20.14.1.10.

The Health Plan has made, or caused to be made, any false statement or representation of a material fact to DHH or CMS in connection with the administration of the Contract;

20.14.1.11.

The Health Plan has furnished goods or services to a member which at the sole discretion of DHH, and based on competent medical judgment and evaluation are determined to be 1) insufficient for his or her needs, 2) harmful to the member, or 3) of grossly inferior quality.

20.15. Notice to CMS

DHH will give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR 438.700 specifying the affected Health Plan, the kind of sanction, and the reason for DHH's decision to lift a sanction. Notice will be given no later than thirty (30) days after DHH imposes or lifts the sanction.

20.16. Federal Sanctions

Section 1903(m)(5)(A) and (B) of the Social Security Act vests the Secretary of the Department of Health and Human Services with the authority to deny Medicaid payments to a Health Plan for members who enroll after the date on which the Health Plan has been found to have committed one or more of the violations identified below. Therefore, whenever, and for so long as, federal payments are denied, DHH shall deduct the total amount of federal payments denied from the next monthly capitation payment made to the Health Plan.

20.16.1.

Substantial failure to provide required medically necessary items or services when the failure had adversely affected (or has substantial likelihood of adversely affecting) a member;

20.16.2.

Discrimination among members with respect to enrollment, re-enrollment, or disenrollment on the basis of the member's health status or requirements for healthcare services;

20.16.3.

Misrepresentation or falsification of certain information; or

20.16.4.

Failure to comply with the requirements for Provider Incentive Plans as specified herein.

20.17. Sanction by CMS—Special Rules Regarding Denial of Payment

Payments provided under this Contract may be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS, in accordance with the requirements in 42 CFR 438.730.

20.18. Payment of Monetary Penalties

20.18.1.

Any monetary penalties assessed by DHH that cannot be collected through withholding from future PMPM payments shall be due and payable to DHH within thirty (30) calendar days after the Health Plan's receipt of the notice of monetary penalties. However, in the event an appeal by the Health Plan results in a decision in favor of the Health Plan, any such funds withheld by DHH will be returned to the Health Plan.

20.18.2.

DHH has the right to recovery of any amounts overpaid as the result of deceptive practices by the Health Plan and/or its contractors, and may consider trebled damages, civil penalties, and/or other remedial measures.

20.18.3.

A monetary sanction may be applied to all known affiliates, subsidiaries and parents of the Health Plan, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the Health Plan is affiliated where such conduct was accomplished within the course of his official duty or was effectuated by him with the knowledge or approval of such person.

20.19. Termination of Health Plan Contract

Nothing in this section shall limit DHH's right to terminate the Contract or to pursue any other legal or equitable remedies. Pursuant to 42 CFR 438.708, DHH may terminate the Contract as a sanction if DHH, at its sole discretion, determines that the Health Plan has failed to 1) carry out the substantive terms of the Contract or 2) meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act.

20.20. Termination for Cause

20.20.1.

DHH may terminate the Contract when DHH determines the Health Plan and/or Health Plan subcontractor(s) have failed to perform, or have violated, substantive terms of the Contract and have failed to meet federal or state requirements.

20.20.2.

DHH will provide the Health Plan with a timely written Notice of Intent to Terminate (Notice). In accordance with 42 CFR 438.708, the Notice will state the nature and basis of the sanction, pre-termination hearing and dispute resolution conference rights, and the time and place of the hearing.

20.20.3.

The termination will be effective no less than thirty (30) calendar days from the date of the Notice of Intent to Terminate. The Health Plan may, at the discretion of DHH, be allowed to correct the deficiencies within the thirty (30) calendar day notice period, unless other provisions in this Section demand otherwise, prior to the issuance of a Notice of Termination.

20.20.4.

In accordance with 42 CFR 438.708, DHH will conduct a pre-termination hearing upon the request of the Health Plan as outlined in the Notice to provide Health Plan the opportunity to contest the nature and basis of the sanction. The Health Plan may request a pre-termination hearing with the Bayou Health Director and/or a dispute resolution conference before the DHH Undersecretary prior to the determined date of termination stated in the Notice.

20.20.5.

The Health Plan shall receive a written notice of the outcome of the pre-termination hearing and/or dispute resolution conference, indicating decision reversal or affirmation.

20.20.6.

The decision by the DHH Undersecretary is the exclusive remedy and LA R.S. 49:950-999.25, the Administrative Procedure Act, does not apply. The Notice of Termination will state the effective date of termination.

20.20.7.

DHH will notify the Medicaid members enrolled in the Health Plan in writing, consistent with 42 CFR 438.710 and 438.722, of the affirming termination decision and of their options for receiving Medicaid services and to disenroll immediately without cause.

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20.21. Termination Due to Serious Threat to Health of Members

DHH may terminate this Contract immediately if it is determined that actions by the Health Plan or its subcontractor(s) pose a serious threat to the health of members enrolled in the Health Plan.

20.22. Termination for Health Plan Insolvency, Bankruptcy, Instability of Funds

20.22.1.

The Health Plan's insolvency or the filing of a petition in bankruptcy by or against the Health Plan shall constitute grounds for termination for cause. If DHH determines the Health Plan has become financially unstable, DHH will immediately terminate this Contract upon written notice to the Health Plan effective the close of business on the date specified.

20.22.2.

The Health Plan shall cover continuation of services to members for the duration of any period for which payment has been made.

20.23. Termination for Ownership Violations

The Health Plan is subject to termination, unless the Health Plan can demonstrate changes of ownership or control, when:

20.23.1.

A person with a direct or indirect ownership interest in the Health Plan:

- Has been convicted of a criminal offense under §§1128(a) and 1128(b)(1), or (3) of the Social Security Act, in accordance with 42 CFR 1002.203;
- Has had civil liquidated damages or assessment imposed under § 1128A of the Social Security Act; or
- Has been excluded from participation in Medicare or any state healthcare program.

20.23.2.

Any individual who has a direct or indirect ownership interest or any combination thereof of 5% or more, or who is an officer (if the Health Plan is organized as a corporation), or who is a partner (if it is organized as a partnership), or who is an agent or a managing employee, has one of the conditions specified in Section 20.23.1.

20.23.3.

The Health Plan has a direct or indirect substantial contractual relationship with an excluded individual or entity. "Substantial contractual relationship" is defined as any direct or indirect business transactions that amount in a single fiscal year to more than \$25,000 or 5% of the Health Plan's total operating expenses, whichever is less.

21. Proposal and Evaluation

21.1. General Information

21.1.1.

This section outlines the provisions which govern determination of compliance of each proposer's response to the RFP.

21.1.2.

DHH shall determine, at its sole discretion, whether or not the requirements have been reasonably met.

21.1.3.

Omissions of required information shall be grounds for rejection of the proposal by DHH.

21.2. Contact after Solicitation Deadline

After the date for receipt of proposals, no proposer-initiated contact relative to the solicitation will be allowed between the proposers and DHH until an award is made.

21.3. Rejection and Cancellation

21.3.1.

Issuance of this solicitation does not constitute a commitment by DHH to award a contract or contracts. The Department reserves the right to reject all proposals received in response to this solicitation.

21.3.2.

In accordance with the provisions of R.S. 39:2182, in awarding contracts after August 15, 2010, any public entity is authorized to reject a proposal or bid from, or not award the contract to, a business in which any individual with an ownership interest of five percent or more, has been convicted of, or has entered a plea of guilty or nolo contendere to any state felony or equivalent federal felony crime committed in the solicitation or execution of a contract or bid awarded under the laws governing public contracts under the provisions of Chapter 10 of Title 38 of the Louisiana Revised Statutes of 1950, professional, personal, consulting, and social services procurement under the provisions of Chapter 16 of this Title, or the Louisiana Procurement Code under the provisions of Chapter 17 of this Title.

21.4. Code of Ethics

Proposers are responsible for determining that there will be no conflict or violation of the Ethics Code if their company is awarded a contract. The Louisiana Board of Ethics is the only entity which can officially rule on ethics issues.

21.5. Award Without Discussion

The Secretary of DHH reserves the right to make an award without presentations by proposers or further discussion of proposals received.

21.6. Assignments

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

21.7. Proposer Prohibition

A proposer shall not submit multiple proposals in different forms. This prohibited action shall be defined as a proposer submitting one proposal as a prime contractor and permitting a second proposer to submit another proposal with the first proposer offered as a subcontractor. This restriction does not prohibit different proposers from offering the same subcontractor as a part of their proposals, provided that the subcontractor does not also submit a proposal as a prime contractor.

21.8. Proposal Cost

The proposer assumes sole responsibility for any and all costs associated with the preparation and reproduction of any proposal submitted in response to this RFP, and shall not include this cost or any portion thereof in the proposed contract price.

21.9. Ownership of Proposal

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

21.10. Procurement Library/Resources Available To Proposer

21.10.1.

Electronic copies of material relevant to this RFP will be posted at the following web address:

<http://www.makingmedicaidbetter.com>.

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21.10.2.

These documents are provided as components of the RFP and are necessary for the submission of the proposal as indicated. The documents consist of appendices, guides, and templates that are an integral part of the contract.

21.10.3.

Potential proposers may receive historic Medicaid de-identified claims data at the parish of residence level for SFY 2011 and SFY 2012, for DBP core benefits DBP populations under the following conditions:

21.10.3.1.

Submit non-binding Letter of Intent to Propose to the RFP Coordinator;

21.10.3.2.

Sign and submit the DBP Data Use Agreement (Appendix H) to the RFP Coordinator; and

21.10.3.3.

Mail or deliver a computer flash drive or hard drive with a capacity of at least 16GB on which to load the historic claims data, along with the name and address to which DHH will mail the data via first class mail, return receipt requested. Alternatively, provide the name of the person who will be picking up and signing for the data at the DHH Bienville Building, 628 North 4th Street , 6th Floor, Baton Rouge, LA . The storage drive and request for routing should be routed to the RFP Coordinator (See Section 1.4.1).

21.10.3.4.

The historical Medicaid claims data will be in SAS7BDAT format.

21.11. Proposal Submission

21.11.1.

All proposals must be received by the due date and time indicated on the Schedule of Events. Proposals received after the due date and time will not be considered. It is the sole responsibility of each proposer to assure that its proposal is delivered at the specified location prior to the deadline. Proposals which, for any reason, are not so delivered will not be considered.

21.11.2.

Proposer shall submit one (1) original hard copy (The Certification Statement must have original signature signed in ink) and should submit one (1) electronic copy (cd or flash drive) of the entire proposal and seven (7) hard copies of the proposal. Proposer may provide one electronic copy of the Redacted (cd or flash drive). No facsimile or emailed proposals will be accepted. The cost proposal and financial statements should be submitted separately from the technical proposal; however, for mailing purposes, all packages may be shipped in one container.

21.11.3.

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

If courier mail or hand delivered:

Mary Fuentes
Department of Health and Hospitals
Division of Contracts and Procurement Support
628 N 4th Street, 5th Floor
Baton Rouge, LA 70802

If delivered via US Mail:

Mary Fuentes
Department of Health and Hospitals
Division of Contracts and Procurement Support

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P.O. Box 1526
Baton Rouge, LA 70821-1526

21.12. Proprietary and/or Confidential Information

21.12.1.

Pursuant to the Louisiana Public Records Act (La. R.S. 44.1 et. seq.), all public proceedings, records, contracts, and other public documents relating to this RFP shall be open to public inspection. Proposers should refer to the Louisiana Public Records Act for further clarification.

21.13. Waiver of Minor Proposal Errors

DHH may, at its sole discretion, waive minor errors or omissions in proposals/forms when those errors do not obscure the meaning of the content.

21.14. Proposal Clarifications

DHH reserves the right to request clarifications from proposers of any information in their proposals/forms, and may request such clarification as it deems necessary at any point in the proposal review process.

21.15. Interpretive Conventions

21.15.1.

Whenever the terms “shall”, or “must,” are used in this RFP in conjunction with a specification or performance requirement, the specification or requirement is mandatory. A proposer’s failure to address or meet any mandatory requirement in a proposal may be cause for DHH’s rejection of the proposal.

21.15.2.

Whenever the terms “can,” “may,” or “should” are used in this RFP in conjunction with a specification or performance requirement, the specification or performance requirement is a desirable, but not mandatory, requirement. Accordingly, a proposer’s failure to address or provide any items so referred to will not be the cause for rejection of the proposal, but will likely result in a less favorable evaluation.

21.16. Proposal Content

21.16.1.

Proposals should include information that will assist the Department in determining the level of quality and timeliness that may be expected. DHH 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. Work samples may be included as part of the proposal.

21.16.2.

Proposals should address how the proposer intends to assume complete responsibility for timely performance of all contractual responsibilities in accordance with federal and state laws, regulations, policies, and procedures.

21.16.3.

Proposals should define proposer’s functional approach in providing services and identify the tasks necessary to meet the RFP requirements of the provision of services, as outlined in the RFP.

21.16.4.

Proposer should demonstrate participation in Veteran Initiative and Hudson Initiative Small Entrepreneurships or explanation if not applicable (Attachment A).

21.16.5.

The Proposer may not submit the Proposer's own contract terms and conditions or other requirements in a response to this RFP.

21.17. Proposal Format

21.17.1.

Each proposal should be economically prepared, with emphasis on completeness and clarity of content. A proposal, as well as any reference material presented, must be written in English and should be typed on standard 8 1/2" x 11" paper with recommended margins of one inch. It should be single spaced with text no smaller than 11-point font; pages may be single sided or double sided. All proposal pages should be numbered and identified with the Proposer's name. Materials should be sequentially filed in three ring binders no larger than three inches in thickness.

21.17.2.

The RFP Appendix AA DBP Proposal Submission and Evaluation Requirements details the specific requirements for making a Proposal in response to this RFP. The Requirements include mandatory and general technical requirements as well as queries requiring a written response.

21.17.3.

All information included in a Proposal should be relevant to a specific requirement detailed in the DBP Proposal Submission and Evaluation Requirements. All information should be incorporated into a response to a specific requirement and clearly referenced. For each response the Proposer should include both the section and number of the requirement and the text of the requirement from the DBP Proposal Submission and Evaluation Requirements.

21.17.4.

The response to the Mandatory Requirements Section (Section A) should be in a separate binder and clearly labeled with contents. The Proposer should duplicate the DBP Proposal Submission and Evaluation Requirements, Section A and use as the Table of Contents. The response to each subsection should be clearly tabbed.

The response to the Technical Requirements Sections (Sections B-F) should be in separate binder (s) and clearly labeled with contents. The Proposer should duplicate the DBP Proposal Submission and Evaluation Requirements, Section B-F and use as the Table of Contents. The response to each subsection (B, C, D, E, F) should be clearly tabbed and labeled.

The responses to the Cost Section (Section 3) should be in a separate binder and clearly labeled with contents. The Proposer should duplicate the DBP Proposal Submission and Evaluation Requirements subsection T. The responses should be clearly tabbed and labeled.

21.17.5.

Attachments should only be provided as requested in the DBP Proposal Submission and Evaluation Requirements and should be clearly labeled, including the Section and number from the Requirements. Any information not meeting these criteria will be deemed extraneous and will in no way contribute to the evaluation process

21.18. Evaluation Criteria

The following criteria will be used to evaluate proposals:

21.18.1.

All proposals will be reviewed and scored for each Section by a Proposal Review Team (PRT), comprised of three or more DHH employees.

21.18.2.

Proposal Review Team members shall sign disclosure forms to establish that they have no personal or financial interest in the outcome of the proposal review and contractor selection process.

21.18.3.

Evaluations of the financial statements and cost proposal will be conducted by a member of the DHH Fiscal Division and other Bayou Health Staff.

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21.18.4.

Each Proposal Evaluation Team member shall evaluate each proposal against the evaluation criteria in this RFP, rather than against other proposals, and scoring will be done by consensus of the PRT assigned to each Section.

21.18.5.

Proposals containing assumptions, lack of sufficient detail, poor organization, lack of proofreading and unnecessary use of self-promotional claims will be evaluated accordingly.

21.18.6.

DHH reserves the right, at its sole discretion, to request Proposer clarification of a Proposal provision or to conduct clarification discussions with any or all Proposers. Any such clarification or discussion shall be limited to specific sections of the proposal identified by DHH. The subject Proposer shall put any resulting clarification in writing as may be required by DHH.

21.18.7.

Scoring will be based on a possible total of 2000 points.

21.19. Evaluation Categories and Maximum Points

DHH will consider each of the factors in the table below in the evaluation of proposals. The maximum points that can be awarded for each of these categories are detailed below.

Section	Category	Total Possible Points
A	Mandatory Requirements	0
B	Qualifications and Experience	150
C	Planned Approach to Project	75
D	Member Enrollment and Disenrollment	20
E	Service Coordination	75
F	Provider Network	100
G	Utilization Management	100
H	EPSDT	25
I	Quality Management	100
J	Member Materials	15
K	Member/Provider Service	100
L	Emergency Management Plan	15
M	Grievance and Appeals	25
N	Fraud and Abuse	25
O	Third Party Liability	25
P	Claims Management	150
Q	Information Systems	150
R	Added Value to Louisiana	100
S	Veteran or Hudson Initiative	200
T	Cost <i>(See Appendix AA, Section 3)</i>	550
TOTAL		2000

21.20. Cost and Price Analysis

21.20.1.

DHH seeks to contract with the most qualified plan based upon the most competitive Per Member Per Month (PMPM) within an actuarially sound range. The rate is intended to cover all benefits and management services outlined in this RFP. DHH will enter into negotiations with the health plan with the highest combined score for the technical evaluation and cost proposal.

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DHH reserve the right to enter into negotiations with additional proposers as needed. The evaluation of proposals received by the specified due date in Section 1.9 will be conducted in the following three (3) phases:

21.20.2. Mandatory Requirements Review

The proposals will be reviewed by DHH contracting officer for completeness to ensure that all mandatory requirements, identified in Appendix AA are submitted and addressed satisfactorily.

21.20.3. Technical Review

The proposals that pass the mandatory requirements review will be technically reviewed for quality and completeness by the technical evaluation team members. These proposals can receive a maximum of 1,450 Technical points. The components of the Technical review are identified in Appendix AA.

Value added services (Section R of Appendix AA) are to be provided at no costs to the state. The State will evaluate the concepts and estimated value of the value added services which are negotiable. Respondents should have the costs associated with innovative concepts available at negotiations.

21.20.4. Cost Review

The cost proposal will be evaluated based on the composite proposed capitation rate. The proposed capitation rates for each Category of Assistance for which a bid is required as specified in Attachment E. The quartiles are scored as follows:

- 1st quartile up to 550 points
- 2nd quartile up to 330 points
- Proposed PMPM rates outside (above or below) quartiles 1 and 2 will receive “0” points

The Health Plan must present a Cost Proposal for the work to be performed. The Health Plan must use the Cost Proposal worksheet provided in Attachment E. The Cost Proposal must be completed in full and detail the proposed capitation payment. Your proposal must include the assumptions used for utilization, unit cost, adjustment, administrative cost, and proposed PMPM. All costs must be reflected in the proposed rates. The Proposer shall consider in the development of their proposed PMPM rates, that if awarded the contract, they will be responsible to pay the 2.25% Health Plan premium tax to the Department of Insurance for Medicaid services according the schedule established by DHH.

The scoring component is designed to cover the competitiveness of a bid as well as the reasonableness of a bid by being within the rate range. The weighted average range points will be calculated from the various category of assistance, as defined by DHH, rate cells using weights developed from State Fiscal Year 2011 and 2012 fee for service per member per month. (Proposer who signs a LOI and a DBP Data Use Agreement shall receive de-identified claims history which will include member months.)

21.21. Announcement of Award

DHH will recommend a contract award to the proposer with the highest graded proposal and that is deemed to be in the best interest of DHH. Proposals are required to receive a minimum of 1,160 Technical points in order to be considered for an award. DHH reserves the right not to award a Contract.

21.21.1. Negotiation of Contract Price and Cancellation of Award

DHH reserves the right to negotiate the final contract price with the successful proposer. If DHH and the proposer are unable to agree on a final contract price, DHH reserves the right to cancel the initial award and make a new award to the proposer with the next highest graded proposal. In that event, the new award will then be subject to the provisions of Sections 20.20–20.21.

21.22. Notice of Contract Award

The notice of intended contract award shall be sent by carriers that require signature upon receipt, by fax with voice confirmation, or by email with reply confirmation to the winning proposers. No proposer shall infer or be construed to have any rights or interest to a contract with DHH until both the proposer and DHH have executed a valid contract and final approval is received from all necessary entities.

22. Turnover Requirements

22.1. Introduction

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

22.2. General Turnover Requirements

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

22.2.1.

Comply with all terms and conditions stipulated in the Contract, including continuation of core benefits and services under the Contract, until the termination effective date;

22.2.2.

Promptly supply all information necessary for the reimbursement of any outstanding claims; and

22.2.3.

Comply with direction provided by DHH to assist in the orderly transition of equipment, services, software, leases, etc. to DHH or a third party designated by DHH.

22.3. Turnover Plan

22.3.1.

In the event of written notification of termination of the Contract by either party, the Health Plan shall submit a Turnover Plan within thirty (30) calendar days from the date of notification, or circumstances necessitate a shorter timeframe, unless other appropriate timeframes have been mutually agreed upon by both the Health Plan and DHH. The Plan shall address the turnover of records and information maintained by the Health Plan relative to core benefits and services provided to Medicaid members for the time form specified by DHH. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by DHH.

22.3.2.

If the Contract is not terminated by written notification as provided in 22.3.1 above, the Health Plan shall propose a Turnover Plan six months prior to the end of the Contract period, including any extensions to such period. The Plan shall address the possible turnover of the records and information maintained to either DHH or a third party designated by DHH. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by DHH.

22.3.3.

As part of the Turnover Plan, the Health Plan must provide DHH with copies of all relevant member and core benefits and services data, documentation, or other pertinent information necessary, as determined by DHH, for DHH or a subsequent Health Plan to assume the operational activities successfully. This includes correspondence, documentation of ongoing outstanding issues, and other operations support documentation. The Plan will describe the Health Plan's approach and schedule for transfer of all data and operational support information, as applicable. The information must be supplied in media and format specified by DHH and according to the schedule approved by DHH.

22.4. Transfer of Data

The Health Plan shall transfer all data regarding the provision of member core benefits and services to DHH or a third party, at the sole discretion of DHH and as directed by DHH. All transferred data must be compliant with HIPAA.

All relevant data must be received and verified by DHH or the subsequent Health Plan. If DHH determines that not all of the data regarding the provision of member core benefits and services to members was transferred to DHH or the subsequent Health Plan, as required, or the data is not HIPAA compliant, DHH reserves the right to hire an independent contractor to

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assist DHH in obtaining and transferring all the required data and to ensure that all the data are HIPAA compliant. The reasonable cost of providing these services will be the responsibility of the Health Plan.

22.5. Post-Turnover Services

Thirty (30) days following turnover of operations, the Health Plan must provide DHH with a Turnover Results report documenting the completion and results of each step of the Turnover Plan. Turnover will not be considered complete until this document is approved by DHH.

If the Health Plan does not provide the required relevant data and reference tables, documentation, or other pertinent information necessary for DHH or the subsequent Health Plan to assume the operational activities successfully, the Health Plan agrees to reimburse DHH for all reasonable costs, including, but not limited to, transportation, lodging, and subsistence for all state and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, reproduction and transfer functions at the location(s) of such records.

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

The Health Plan must maintain all files and records related to members and providers for five years after the date of final payment under the Contract or until the resolution of all litigation, claims, financial management review or audit pertaining to the Contract, whichever is longer. The Health Plan agrees to repay any valid, undisputed audit exceptions taken by DHH in any audit of the Contract.

23. Terms and Conditions

It is anticipated the Contract effective date to be March 1, 2013 through January 31, 2014 with two (2) one year options for renewal; unless terminated prior to that date in accordance with state or federal law or terms of the Contract. DHH reserves the right to renew the contract at the same terms and conditions or may renegotiate the PMPM based on budget adjustments, utilization efficiencies, or other factors as deemed necessary by DHH.

DHH will provide the Contractor sixty (60) days prior notice of such change to provide the Contractor the opportunity to prepare for the on-site Readiness Review. The Health Plan shall successfully complete a readiness review as specified in Section 19.5 of this RFP prior to the effective date. If the Health Plan does not pass the readiness review the Contract shall be terminated by DHH.

The Health Plan shall comply with all state and federal laws, regulations, and policies as they exist or as amended that are or may be applicable to this Contract, not specifically mentioned in this section, including those in the DHH pro forma contract. Any provision of this Contract which is in conflict with federal statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal policy. Such amendment of the Contract will be effective on the effective date of the statutes, regulations, or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties. The Health Plan may request DHH to make policy determinations required for proper performance of the services under this Contract.

23.1. Amendments

The Contract may be amended at any time as provided in this paragraph. The Contract may be amended whenever appropriate to comply with state and federal requirements or state budget reductions or as deemed necessary to meet the goals of the Bayou Health Program. No modification or change of any provision of the Contract shall be made or construed to have been made unless such modification is mutually agreed to in writing by the Health Plan and DHH, and incorporated as a written amendment to the Contract. Any amendment to the Contract shall require approval by DHH, the Division of Administration Office of Contractual Review and may require approval of the CMS Regional Office prior to the amendment implementation.

DHH reserves the right to provide written clarification for non-material changes of contract requirements whenever deemed necessary, at any point in the contract period, to ensure the smooth operations of the Bayou Health Program. Such clarifications shall be implemented by the CCN and will not require an amendment to the Contract.

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23.2. Applicable Laws and Regulations

The Health Plan shall comply with all applicable federal and state laws and regulations including Constitutional provisions regarding due process and equal protection under the laws and including but not limited to:

23.2.1.

Title 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter C (Medical Assistance Programs);

23.2.2.

All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. 7401, et seq.) and 20 USC §6082(2) of the Pro-Children Act of 1994, as amended (P.L. 103-227);

23.2.3.

Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. 2000d) and regulations issued pursuant thereto, 45 CFR part 80; In accordance with Title VI of the Civil Rights Act of 1964 (42U.S.C. 2000d et seq.) and its implementing regulation at 45 CFR Part 80, the Health Plan must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Contract;

23.2.4.

Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. 2000e) in regard to employees or applicants for employment;

23.2.5.

Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84;

23.2.6.

The Age Discrimination Act of 1975, as amended, 42 U.S.C § 6101 et seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance;

23.2.7.

The Omnibus Budget Reconciliation Act of 1981, as amended, P.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance;

23.2.8.

The Balanced Budget Act of 1997, as amended, P.L. 105-33 and the Balanced Budget Refinement Act of 1999, as amended, H.R. 3426;

23.2.9.

The Americans with Disabilities Act, as amended, 42 U.S.C. §12101 et seq., and regulations issued pursuant thereto;

23.2.10.

Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusion of the Health Plan for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

23.2.11.

All applicable standards, orders, or regulations issued pursuant to the Louisiana Revised Statute 49:1001 – 1021;

23.2.12.

The Federal Drug Free Workplace Act of 1988 as set forth in 45 CFR Part 82;

23.2.13.

Title IX of the Education Amendments of 1972 regarding education programs and activities; and

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23.2.14.

Byrd Anti-Lobbying Amendment Contractors who apply or bid shall file the require certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded form tier to tier up to the recipient (45 CFR Part 3).

23.3. Assessment of Fees/Payment of Premium Taxes

23.3.1.

The Contractor and DHH agree that DHH may elect to deduct any assessed fees from payments due or owing to the Health Plan or direct the Health Plan to make payment directly to DHH for any and all assessed fees. The choice is solely and strictly DHH's.

23.3.2.

The Health Plan shall be responsible for payment of all premium taxes paid through the capitation payments by DHH to the Louisiana Department of Insurance according to the schedule established by DHH.

23.4. Attorney's Fees

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

23.5. Board Resolution/Signature Authority

The Health Plan if a corporation shall secure and attach to the Contract a formal Board Resolution indicating the signatory to the Contract is a corporate representative and authorized to sign said Contract.

23.6. Confidentiality of Information

23.6.1.

The Health Plan shall comply with the HIPAA Privacy Rule, with other applicable federal and state laws and regulations, and with the provisions of this Contract in its use and disclosure of medical records and any and all other health and enrollment information relating to members or potential members, which is provided to or obtained by or through the Health Plan's performance under this Contract, whether verbal, written, electronic file, or otherwise, The Health Plan shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Contract.

23.6.2.

All information as to personal facts and circumstances concerning members or potential members obtained by the Health Plan shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of DHH or the member/potential member unless required by applicable state or federal law or otherwise permitted by the HIPAA Privacy Rule, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of this Contract.

23.7. Conflict of Interest

The Health Plan may not contract with Louisiana Medicaid unless such safeguards at least equal to federal safeguards (41 USC 423:27) are in place per state Medicaid Director letter dated December 30, 1997 and 1932 (d)(3) of the Social Security Act addressing 1932 State Plan Amendment and the default enrollment process under the State Plan Amendment option.

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23.8. Contract Language Interpretation

Subject to Section 23.30 of the RFP, the Health Plan and DHH agree that in the event of a disagreement regarding, arising out of, or related to, Contract language interpretation, DHH's interpretation of the Contract language in dispute shall control and govern.

23.9. Cooperation with Other Contractors

23.9.1.

In the event that DHH has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder including but not limited to fiscal intermediary and enrollment broker services, the Health Plan agrees to cooperate fully with such other contractors. The Health Plan shall not commit any act that will interfere with the performance of work by any other contractor.

23.9.2.

The Health Plan's failure to cooperate and comply with this provision, shall be sufficient grounds for DHH to halt all payments due or owing to the Health Plan until it becomes compliant with this or any other contract provision. DHH's determination on the matter shall be conclusive and not subject to Appeal.

23.10. Copyrights

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

23.11. Corporation Requirements

If the Health Plan is a corporation, the following requirement must be met prior to execution of the Contract:

23.11.1.

If a for-profit corporation whose stock is not publicly traded, the Health Plan must file a Disclosure of Ownership form with the Louisiana Secretary of State.

23.11.2.

If the Health Plan is a corporation not incorporated under the laws of the state of Louisiana, the Health Plan must obtain a Certificate of Authority pursuant to R.S. 12:301-302 from the Louisiana Secretary of State.

23.11.3.

The Health Plan must provide written assurance to DHH from the Health Plan's legal counsel that the Health Plan 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.

23.12. Debarment/Suspension/Exclusion

23.12.1.

The Health Plan agrees to comply with all applicable provisions of 42 CFR Part 376 (2009, as amended), pertaining to debarment and/or suspension. As a condition of enrollment, the Health Plan must screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or all federal healthcare programs. To help make this determination, the Health Plan may search the following websites: Office of Inspector General (OIG) List of Excluded Individuals/Entities LEIE <http://exclusions.oig.hhs.gov/search.aspx>; the Health Integrity and Protection Data Bank (HIPDB) <http://www.npdb-hipdb.hrsa.gov/index.jsp> and/or the Excluded Parties List Serve (EPLS) www.EPLS.gov.

23.12.2.

The Health Plan shall conduct a search of the website monthly to capture exclusions and reinstatements that have occurred since the last search and any exclusion information discovered should be immediately reported to DHH. Any individual or entity that employs or subcontracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid

payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against providers who employ or enter into provider contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR 1003.102(a)(2).

23.13. Effect of Termination on Health Plan's HIPAA Privacy Requirements

23.13.1.

Upon termination of this Contract for any reason, the Health Plan shall return or destroy all Protected Health Information received from DHH, or created or received by the Health Plan on behalf of DHH. This provision shall also apply to Protected Health Information that is in the possession of subcontractors or agents of the Health Plan. The Health Plan shall not retain any copies of the Protected Health Information.

23.13.2.

In the event that the Health Plan determines that returning or destroying the Protected Health Information is not feasible, the Health Plan shall provide to DHH notification of the conditions that make return or destruction not feasible. Upon a mutual determination that return or destruction of Protected Health Information is not feasible, the Health Plan shall extend the protections of the Contract to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction not feasible, for so long as the Health Plan maintains such Protected Health Information.

23.14. Emergency Management Plan

23.14.1.

The Health Plan shall submit an emergency management plan within forty-five (45) days from the date the Contract is signed by the Health Plan, but no later than prior to the Readiness Review, to DHH for approval but prior to the Readiness Review. The emergency management plan shall specify actions the Health Plan shall conduct to ensure the ongoing provision of health services in an epidemic, disaster or manmade emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies. Revisions to the DHH approved emergency plan shall be submitted to DHH for approval no less than 30 days prior to implementation of requested changes. The Health Plan shall submit an annual certification (from the date of the most recently approved plan) to DHH certifying that the emergency plan is unchanged from the previously approved plan.

23.14.2.

At a minimum, the plan should include the following:

23.14.2.1.

Educating members and providers regarding hurricane preparedness and evacuation planning;

23.14.2.2.

Provide a Health Plan contact list (phone and email) for members and providers to contact to determine where healthcare services may be accessed/rendered;

23.14.2.3.

Use of EHR to provide healthcare providers access to member's health history and receive information of care provided during evacuation; and

23.14.2.4.

Emergency contracting with out-of-state healthcare providers to provide healthcare services to evacuated members.

23.15. Employee Education about False Claims Recovery

If the Health Plan receives annual Medicaid payments of at least \$5,000,000, the Health Plan must comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005.

23.16. Employment of Personnel

23.16.1.

In all hiring or employment made possible by or resulting from this Contract, the Health Plan agrees that:

23.16.1.1.

There shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, or national origin; and

23.16.1.2.

Affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all state and federal laws applicable to employment of personnel.

23.16.2.

This requirement shall apply to, but not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training including apprenticeship. The Health Plan further agrees to give public notice in conspicuous places available to employees and applicants for employment setting forth the provisions of this section. All solicitations or advertisements for employees shall state that all qualified applicants will receive consideration for employment without regard to handicap, age, race, color, religion, sex, or national origin. All inquiries made to the Health Plan concerning employment shall be answered without regard to handicap, age, race, color, religion, sex, or national origin. All responses to inquiries made to the Health Plan concerning employment made possible as a result of this Contract shall conform to federal, state, and local regulations.

23.17. Entire Contract

This Contract, together with the RFP and addenda issued thereto by DHH, the proposal submitted by the proposer in response to DHH's RFP, and any exhibits specifically incorporated herein by reference constitute the entire agreement between the parties with respect to the subject matter.

The Health Plan shall comply with all provisions of the Contract and shall act in good faith in the performance of the provisions of said Contract. The Health Plan shall be bound by all applicable Department issued guides. The Health Plan agrees that failure to comply with the provisions of the Contract may result in the assessment of monetary penalties, sanctions and/or termination of the Contract in whole or in part, as set forth in the Contract. The Health Plan shall comply with all applicable DHH policies and procedures in effect throughout the duration of the Contract period. The Health Plan shall comply with all applicable DHH provider manuals, rules, regulations, and guides.

DHH, at its discretion, will issue correspondence to inform the Health Plan of changes in Medicaid policies and procedures which may affect the Contract. **Unless otherwise specified** in the Medicaid correspondence the Health Plan will be given sixty (60) calendar days to implement such changes.

23.18. Force Majeure

The Health Plan and DHH may be excused from performance under this Contract for any period they may be prevented from performance by an Act of God; strike, war, civil disturbance or court order. The Health Plan shall, however, be responsible for the development and implementation of an Emergency Management Plan as specified in Section 23.14.

23.19. Fraudulent Activity

23.19.1. The Health Plan shall report to DHH any cases of suspected Medicaid fraud or abuse by its members, network providers, employees, or subcontractors. The Health Plan shall report such suspected fraud or abuse in writing as soon as practical after discovering suspected incidents, but no more than three (3) business days. The Health Plan shall report the following fraud and abuse information to DHH:

23.19.1.

The number of complaints of fraud and abuse made to the Health Plan that warrant preliminary investigation; and

23.19.2.

For each case of suspected provider fraud and abuse that warrants a full investigation:

- the provider's name and number
- the source of the complaint
- the type of provider
- the nature of the complaint
- the approximate range of dollars involved
- the legal and administrative disposition of the case

23.19.3.

The Health Plan shall adhere to the policy and process contained in this RFP for referral of cases and coordination with the DHH's Program Integrity Unit for fraud and abuse complaints regarding members and providers.

23.20. Governing Law and Place of Suit

It is mutually understood and agreed that this Contract shall be governed by the laws of the state of Louisiana except its conflict of laws provision both as to interpretation and performance. Any administrative proceeding, action at law, suit in equity, or judicial proceeding for the enforcement of this Contract or any provision thereof shall be instituted only in the appropriate administrative tribunals and courts of the state of Louisiana. Specifically, any state court suit shall be filed in the 19th Judicial District Court for East Baton Rouge Parish as the exclusive venue for same, and any federal suit shall be filed in the U.S. District Court for the Middle District for the state of Louisiana as the exclusive venue for same. This section shall not be construed as providing a right / cause of action to the Health Plan in any of the aforementioned Courts.

23.21. HIPAA Business Associate

Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule as agreed upon in the HIPAA Business Associate Agreement, Attachment D.

23.22. HIPAA Compliance

The Health Plan shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (the HITECH Act) and the rules and regulations promulgated there under (45 CFR Parts 160, 162, and 164). The Health Plan shall ensure compliance with all HIPAA requirements across all systems and services related to this Contract, including transaction, common identifier, and privacy and security standards, by the effective date of those rules and regulations.

23.23. Hold Harmless

23.23.1.

The Health Plan shall indemnify, defend, protect, and hold harmless DHH and any of its officers, agents, and employees from:

23.23.1.1.

Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for the Health Plan in connection with the performance of this Contract;

23.23.1.2.

Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by Health Plan, its agents, officers, employees, or subcontractors in the performance of this Contract;

23.23.1.3.

Any claims for damages or losses resulting to any person or firm injured or damaged by the Health Plan, its agents, officers, employees, or subcontractors by Health Plan's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Contract in a manner not authorized by the Contract or by federal or state regulations or statutes;

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23.23.1.4.

Any failure of the Health Plan, its agents, officers, employees, or subcontractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;

23.23.1.5.

Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of DHH in connection with the defense of claims for such injuries, losses, claims, or damages specified above; and

23.23.1.6.

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

23.23.2.

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

23.23.3.

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

23.24. Hold Harmless as to the Health Plan Members

23.24.1.

The Health Plan hereby agrees not to bill, charge, collect a deposit from, seek cost sharing or other forms of compensation, remuneration or reimbursement from, or have recourse against, Health Plan members, or persons acting on their behalf, for healthcare services which are rendered to such members by the Health Plan and its subcontractors, and which are core benefits and services.

23.24.2.

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

23.24.3.

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

23.25. Homeland Security Considerations

23.25.1.

The Health Plan shall perform the services to be provided under this Contract entirely within the boundaries of the United States. In addition, the Health Plan will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

23.25.2.

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

23.25.3.

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

23.26. Incorporation of Schedules/Appendices

All schedules/appendices referred to in this RFP are attached hereto, are expressly made a part hereof, and are incorporated as if fully set forth herein.

23.27. Independent Provider

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

23.28. Integration

This Contract and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. The Health Plan also agrees to be bound by the Contract and any rules or regulations that may be promulgated. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or affect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved by the parties.

23.29. Interest

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

23.30. Interpretation Dispute Resolution Procedure

23.30.1.

The Health Plan may request in writing an interpretation of the issues relating to the Contract from the Bayou Health Director. In the event the Health Plan disputes the interpretation by the Bayou Health Director, the Health Plan shall submit a written reconsideration request to the Medicaid Director.

23.30.2.

The Health Plan shall submit, within twenty-one (21) days of said interpretation, a written request disputing the interpretation directly to the Medicaid Director. The ability to dispute an interpretation does not apply to language in the Contract that is based on federal or state statute, regulation or case law.

23.30.3.

The Medicaid Director shall reduce the decision to writing and provide a copy to the Health Plan. The written decision of the Medicaid Director shall be final of DHH. The Medicaid Director will render his/her final decision based upon the written submission of the Health Plan and the Bayou Health Director, unless, at the sole discretion of the Medicaid Director, the Medicaid Director allows an oral presentation by the Health Plan and the Bayou Health Director or his/her designee. If such a presentation is allowed, the information presented will be considered in rendering the decision.

23.30.4.

Pending final determination of any dispute over a DHH decision, the Health Plan shall proceed diligently with the performance of the Contract and in accordance with the direction of DHH.

23.31. Loss of Federal Financial Participation (FFP)

The Health Plan hereby agrees to be liable for any loss of FFP suffered by DHH due to the Health Plan's, or its subcontractors', failure to perform the services as required under this Contract. Payments provided for under this Contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR 438.730.

23.32. Misuse of Symbols, Emblems, or Names in Reference to Medicaid

No person or Health Plan may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems the words "Louisiana Medicaid," or "Department of Health and Hospitals" or "Bureau of Health Services Financing," unless prior written approval is obtained from DHH. Specific written authorization from DHH is required to reproduce, reprint, or distribute any DHH form, application, or publication for a fee. State and local governments are exempt from this prohibition. A disclaimer that accompanies the inappropriate use of program or DHH terms does not provide a defense. Each piece of mail or information constitutes a violation.

23.33. National Provider Identifier (NPI)

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

23.34. Non-Discrimination

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

23.35. Non-Waiver of Breach

23.35.1.

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

23.35.2.

Waiver of any breach of any term or condition in this Contract shall not be deemed a waiver of any prior or subsequent breach. No term or condition of this Contract shall be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties hereto.

23.36. Offer of Gratuities

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

23.37. Order of Precedence

In the event of any inconsistency or conflict among the document elements of this Contract, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

- The body of the Contract with exhibits and attachments excluding the RFP and the contractor's proposal;

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- This RFP and any addenda and appendices;
- DBP Systems Companion Guide;
- DBP Quality Companion Guide; and
- The Proposal submitted by the Health Plan in response to this RFP.

23.38. Provider Incentive Plans

23.38.1.

The Health Plan shall comply with requirements for Provider Incentive Plans, as described in 42 CFR 438.6(h) and set forth (for Medicare) in 42 CFR §§ 422.208 and 422.210.

23.38.2.

Assurances to CMS. Each organization will provide to DHH assurance satisfactory to the Secretary of HHS that the requirements of 42 CFR Sec. §422.208 are met.

23.39. Political Activity

None of the funds, materials, property, or services provided directly or indirectly under this Contract shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the "Hatch Act".

23.40. Prohibited Payments

Payment for the following shall not be made:

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

23.41. Rate Adjustments

The DHH agreed upon monthly capitation rates shall be in effect during the period identified on the in their contract. Rates may be adjusted during the Contract period and subject to CMS review and approval.

The Health Plan and DHH both agree that the adjustments to the monthly capitation rate(s) required pursuant to this section shall occur only by written amendment to the Contract. Should either the Health Plan or DHH refuse to accept the revised monthly capitation rate, the provisions of the RFP for contract termination and turnover shall apply.

23.42. Record Retention for Awards to Recipients

Financial records, supporting documents, statistical records, and all other records pertinent to an award shall be retained for a period of six (6) years from the date of submission of the final expenditure report, or for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report. The only exceptions are the following:

23.42.1.

If any litigation, claim, financial management review, or audit is started before the expiration of the six (6) year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken;

23.42.2.

Records for real property and equipment acquired with federal funds shall be retained for six (6) years after final disposition;

23.42.3.

When records are transferred to or maintained by DHH, the six (6) year retention requirement is not applicable to the recipient; and

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23.42.4.

Indirect cost rate proposals, cost allocations plans, etc., as specified in 45 CFR 74.53 (g).

23.43. Release of Records

The Health Plan shall release medical records upon request by members or authorized representative, as may be directed by authorized personnel of DHH, appropriate agencies of the State of Louisiana, or the United States Government and subject to reasonable charges. Release of medical records shall be consistent with the provisions of confidentiality as expressed in this Contract. The ownership and procedure for release of medical records shall be controlled by the Louisiana revised statutes, including but not limited to, La.R.S. 40:1299.96, La.R.S. 13:3734, and La.C.Ev. Art. 510; and the 45 CFR Parts 160 and 164 (HIPAA Privacy Rule) and subject to reasonable charges. The Health Plan shall not charge DHH/BHSF or their designated agent for any copies requested.

23.44. Reporting Changes

The Health Plan shall immediately notify DHH of any of the following:

- Change in business address, telephone number, facsimile number, and email address;
- Change in corporate status or nature;
- Change in business location;
- Change in solvency;
- Change in corporate officers, executive employees, or corporate structure;
- Change in ownership, including but not limited to the new owner's legal name, business address, telephone number, facsimile number, and email address;
- Change in incorporation status;
- Change in federal employee identification number or federal tax identification number; or
- Change in Health Plan litigation history, current litigation, audits and other government investigations both in Louisiana and in other states.

23.45. Safeguarding Information

The Health Plan shall establish written safeguards which restrict the use and disclosure of information concerning members or potential members to purposes directly connected with the performance of this Contract. The Health Plan's written safeguards shall

- Be comparable to those imposed upon the DHH by 42 CFR Part 431, Subpart F (2005, as amended) and La R.S. 45:56;
- State that the Health Plan will identify and comply with any stricter state or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;
- Require a written authorization from the member or potential member before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR § 164.508;
- Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and
- Specify appropriate personnel actions to sanction violators.

23.46. Safety Precautions

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

23.47. Severability

If any provision of this Contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both DHH and Health Plan shall be relieved of all obligations arising under such provision. If the remainder of this Contract is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed. In addition, if the laws or regulations governing this Contract should be amended or judicially interpreted as to render the fulfillment of the Contract impossible or economically infeasible, both DHH and the Health Plan will be discharged from further obligations created under the terms of the Contract.

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23.48. Software Reporting Requirement

All reports submitted to DHH by the Health Plan must be in format accessible and modifiable by the standard Microsoft Office Suite of products, Version 2003 or later, or in a format accepted and approved by DHH.

23.49. Termination for Convenience

DHH may terminate this Contract for convenience and without cause upon sixty (60) calendar days written notice. DHH shall not be responsible to the Health Plan or any other party for any costs, expenses, or damages occasioned by said termination, i.e., this termination is without penalty.

23.50. Termination for Unavailability of Funds

In the event that federal and/or state funds to finance this Contract become unavailable after the effective date of this Contract, or prior to the anticipated Contract expiration date, DHH may terminate the Contract without penalty. This notification will be made in writing. Availability of funds shall be determined solely by DHH.

23.51. Time is of the Essence

Time is of the essence in this Contract. Any reference to "days" shall be deemed calendar days unless otherwise specifically stated.

23.52. Titles

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

23.53. Use of Data

DHH shall have unlimited rights to use, disclose, or duplicate, for any purpose, all information and data developed, derived, documented, or furnished by the Health Plan resulting from this Contract.

23.54. Waiver

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

23.55. Warranty to Comply with State and Federal Regulations

The Health Plan shall warrant that it shall comply with all state and federal regulations as they exist at the time of the Contract or as subsequently amended.

23.56. Warranty of Removal of Conflict of Interest

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

24. Glossary

Action - The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service, the failure to provide services in a timely manner as defined by §7.3 and § 7.5 of this RFP; or the failure of the Health Plan to act within the timeframes provided in §13.7.1 of this RFP.

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

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet

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professionally recognized standards for healthcare. It also includes member practices that result in unnecessary cost to the Medicaid program.

Action - The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service, the failure to provide services in a timely manner (as defined by DHH), and the failure of the Health Plan to act within the timeframes for the resolution of grievances and appeals as described in 42 CFR 438.400(b); and in a rural area with only one Health Plan, the denial of a member's right to obtain services outside the provider network, as described in 438.52(b)(2)(ii).

Actuarially Sound PMPM rates - PMPM rates that (1) have been developed in accordance with generally accepted actuarial principles and practices; (2) are appropriate for the populations to be covered, and the services to be furnished under the Contract; and (3) have been certified, as meeting the requirements of this definition, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

Acute Care - Means preventive care, primary care, and other medical care provided under the direction of a dentist or physician for a condition having a relatively short duration.

Adequate Network/Adequacy of Network – This refers to the network of healthcare providers for the Health Plan that is sufficient in numbers and types of providers and facilities to ensure that all services are accessible to members without unreasonable delay. Adequacy is determined by a number of factors, including but not limited to, provider-patient ratios for primary care dentists; geographic accessibility and travel distance; waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments and hours of provider operations.

Adjudicate - means to deny or pay a clean claim.

Adjustments to Smooth Data – Adjustments made, by cost-neutral methods, across rate cells, to compensate for distortions in costs, utilization, or the number of eligibles.

Administrative Services - means the performance of services or functions, other than the direct delivery of core benefits and services, necessary for the management of the delivery of and payment for core benefits and services, including but not limited to network, utilization, clinical and/or quality management, service authorization, claims processing, management information systems operation, and reporting.

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

Adverse Action – Any decision by the Health Plan to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested in accordance with 42 CFR 438.214(c).

Adverse Determination An admission, availability of care, continued stay or other healthcare service that has been reviewed by the Health Plan and based upon the information provided, does not meet the Health Plan's requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness, and the requested service is therefore denied, reduced, suspended, delayed or terminated.

Affiliate - means any individual or entity that meets any of the following criteria:

1. owns or holds more than a five percent (5%) interest in the Health Plan (either directly, or through one (1) or more intermediaries); means any individual or entity that meets any of the following criteria:
2. in which the Health Plan owns or holds more than a five percent (5%) interest (either directly, or through one (1) or more intermediaries);
3. any parent entity or subsidiary entity of the Health Plan regardless of the organizational structure of the entity;
4. any entity that has a common parent with the Health Plan (either directly, or through one (1) or more intermediaries);
5. any entity that directly, or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, the Health Plan; or

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6. any entity that would be considered to be an affiliate by any Securities and Exchange Commission (SEC) or Internal Revenue Service (IRS) regulation, Federal Acquisition Regulations (FAR), or by another applicable regulatory body.

Age Discrimination Act of 1975 - prohibits discrimination on the basis of age in programs and activities receiving federal financial assistance. The Act, which applies to all ages, permits the use of certain age distinctions and factors other than age that meet the Act's requirements. The Age Discrimination Act is enforced by the Office for Civil Rights.

Aged/Blind/Disabled - means the categories of individuals who meet the Medicaid eligibility factor of age, blindness, or a mental and/or physical disability.

Agent - An entity that contracts with DHH to perform administrative functions, including but not limited to fiscal intermediary activities, outreach, eligibility, and enrollment activities, systems and technical support, etc.

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

American Dental Association (ADA) – The American Dental Association is the professional association of dentist that works to advance the dental profession on the national, state, and local levels.

Americans with Disabilities Act of 1990 (ADA) – The Americans with Disabilities act prohibits discrimination against people with disabilities in employment, transportation, public accommodation, communications and governmental activities. The ADA also establishes requirements for telecommunications relay services.

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

Appeal – A request for a review of an action pursuant to 42 CFR 438.400(b).

Appeal Procedure - A formal process whereby a member has the right to contest an adverse determination/action rendered by the Health Plan, which results in the denial, reduction, suspension, termination or delay of healthcare benefits/services. The appeal procedure shall be governed by Louisiana Medicaid rules and regulations and any and all applicable court orders and consent decrees.

Benefits or Covered Services - Those healthcare services to which an eligible Medicaid recipient is entitled under Louisiana Medicaid State Plan.

Blocked Call - A call that cannot be connected immediately because no circuit is available at the time the call arrives or the telephone system is programmed to block calls from entering the queue when the queue backs up beyond a defined threshold.

Bureau of Health Services Financing (BHSF) - The agency within the Louisiana Department of Health & Hospitals, Office of Management & Finance that has been designated as Louisiana's single state Medicaid agency to administer the Medicaid and CHIP programs.

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

Business Day - Traditional workdays, including Monday, Tuesday, Wednesday, Thursday and Friday. State holidays are excluded and traditional work hours are 8:00 a.m. – 5:00 p.m. , unless the context clearly indicates otherwise.

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

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CDT® - Current Dental Terminology, current version, is a code set with descriptive terms developed and updated by the [American Dental Association](#) (ADA) for reporting [dental](#) services and procedures to dental benefits plans. DHHS designated the CDT code set as the national terminology for reporting dental services.

CMS 1500 - Universal claim form, required by CMS, to be used by non-institutional and institutional providers that do not use the UB-92.

CPT® - Current Procedural Terminology, current version, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. DHHS designated the CPT code set as the national coding standard for physician and other healthcare professional services and procedures under HIPAA.

Calendar Days - All seven (7) days of the week. Unless otherwise specified, the term “days” in the Contract refers to calendar days.

Capitation - A contractual agreement through which the Health Plan agrees to provide specified core health benefits and services to members for a fixed amount per month.

Capitation Payment - A payment, fixed in advance, that DHH makes to the Health Plan for each member covered under the Contract for the provision of core health benefits and services and assigned to the Health Plan. This payment is made regardless of whether the member receives core benefits and services during the period covered by the payment.

Capitation Rate - The fixed monthly amount that the Health Plan is prepaid by DHH for each member assigned to the Health Plan to ensure that core benefits and services under this Contract are provided.

Capitated Service - Any core benefit or service for which the Health Plan receives an actuarially sound capitation payment.

Care Coordination – Deliberate organization of patient care activities by a person or entity formally designated as primarily responsible for coordinating services furnished by providers involved in the member’s care to facilitate care within the network with services provided by non-network providers to ensure appropriate delivery of healthcare services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of member’s care.

Care Management - Overall system of medical management encompassing Utilization Management, Referral, Case Management, Care Coordination, Continuity of Care and Transition Care, Chronic Care Management, Quality Care Management, and Independent Review.

Case Management – Refers to a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a member’s needs through communication and available resources to promote high quality, cost-effective outcomes. Case management services are defined as services provided by qualified staff to a targeted population to assist them in gaining timely access to the full range of needed services including medical, social, educational, and other support services. Case Management services include an individual needs assessment and diagnostic assessment, individual treatment plan development, establishment of treatment objectives, and monitoring outcomes.

Case Manager - A person who is either a degreed social worker, licensed registered nurse, or a person with a minimum of two years experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities. Case management manager shall not provide direct care services to members enrolled with the Contractor, but shall authorize appropriate services and/or refer members to appropriate services.

Cause - Term may also be referred to as “good cause.”

Centers for Medicare and Medicaid Services (CMS) - The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children’s Health Insurance Program under Title XXI of the Social Security Act. Formerly known as Healthcare Financing Administration (HCFA)

CHIP – Children’s Health Insurance Program created in 1997 by Title XXI of the Social Security Act. Known in Louisiana as CHIP

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

Chronic Condition - persistent or frequently recurring conditions of significant duration that may limit an individual's activities and require ongoing medical care to optimize the individual's quality of life.

Chronic Care Management - The concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care.

Claim – means 1) a bill for services 2) a line item of service or 3) all services for one recipient within a bill.

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

Co-branding – a relationship between two or more separate legal entities, one of which is a Health Plan. The plan displays the name(s) or brand(s) of the co-branding entity or entities on its marketing materials to signify a business arrangement. Co-branding relationships are entered into independent of the contract that the Health Plan has with DHH.

Cold Call Marketing – Any unsolicited personal contact with a Medicaid eligible individual by the Health Plan, its staff, its volunteers or its vendors/contractors with the purpose of influencing the Medicaid eligible individual to enroll in the Health Plan.

Comprehensive Risk Contract – A contract that covers inpatient hospital services and any of the following services or any of three or more of the following services, outpatient hospital services, rural health clinic services, FHQC services; other laboratory and X-ray service; nursing facility services; early periodic screening, diagnostic, and treatment services; family planning services; physician services; or home health services.

Contract– The written agreement between DHH and the Health Plan; comprised of the RFP, Contract, any addenda, appendices, attachments, or amendments thereto.

Contract Dispute - A circumstance whereby the Health Plan and their subcontractor are unable to arrive at a mutual interpretation of the requirements, limitations, or compensation for the performance of services under their contract.

Convicted – A judgment of conviction entered by a federal, state or local court, regardless of whether an appeal from that judgment is pending.

Contract Term – The period for which the Contract is written

Coordination of Benefits (COB) - Refers to the activities involved in determining Medicaid benefits when a recipient has coverage through an individual, entity, insurance, or program that is liable to pay for healthcare services.

Copayment - Any cost sharing payment for which the Medicaid Health Plan member is responsible, in accordance with 42 CFR 447.50 and Section 5006 of the American Recovery and Reinvestment Act (ARRA) for Native American members.

Core Benefits and Services - A schedule of healthcare benefits and services required to be provided by the Health Plan to Medicaid members as specified under the terms and conditions of this RFP and Contract and the Louisiana Medicaid State Plan.

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

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

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Cost-Based Reimbursement - A method of payment of medical care by third parties for services delivered to patients. The amount of payment is based on the allowable costs to the provider for delivering the service.

Cost Neutral – The mechanism used to smooth data, share risk, or adjust for risk that will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments.

Covered Services - Those healthcare services/benefits to which an individual eligible for Medicaid or CHIP is entitled under the Louisiana Medicaid State Plan.

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

DBP Systems Companion Guide – A supplement to the Contract that outlines the formatting and reporting requirements concerning encounter data, interfaces between the FI and the Health Plan and enrollment broker and the Health Plan.

DHH Administrative Regions – The nine Louisiana geographic areas designated in state statute for administrative purposes. Each geographic area is comprised of specific parishes. For specific areas see http://www.dhh.louisiana.gov/offices/medialibrary/media-1/REG_MAP04.jpg

Deliverable - A document, manual or report submitted to DHH by the Health Plan to fulfill requirements of this Contract.

Denied Claim - A claim for which no payment is made to the network provider by the Health Plan for any of several reasons, including but not limited to, the claim is for non-covered services, an ineligible provider or recipient, or is a duplicate of another transaction, or has failed to pass a significant requirement in the claims processing system.

Dental Director - The licensed dentist designated by the Health Plan to exercise general supervision over the provision of core benefits and services by the Health Plan.

Department (DHH) – The Louisiana Department of Health and Hospitals, referred to as DHH throughout this RFP

Direct Marketing/Cold Call - Any unsolicited personal contact with or solicitation of a Medicaid eligible in person, through direct mail advertising or telemarketing by an employee or agent of the Health Plan for the purpose of influencing an individual to enroll with the Health Plan.

Disease Management (DM) – see Chronic Care Management

Disenrollment - The removal of a member from participation in the Health Plan's plan, but not necessarily from the Medicaid or LaCHIP Program.

Documented Attempt - A bona fide, or good faith, attempt, in writing, by the Health Plan to contract with a provider, made on or after the date the Health Plan signs the Contract with DHH. Such attempts may include written correspondence that outlines contract negotiations between the parties, including rate and contract terms disclosure. If, within 10 calendar days, the potential network provider rejects the request or fails to respond either verbally or in writing, the Health Plan may consider the request for inclusion in the Health Plan's network denied by the provider. This shall constitute one attempt.

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

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) - A federally required Medicaid benefit for individuals under the age of 21 years that expands coverage for children and adolescents beyond adult limits to ensure availability of 1) screening and diagnostic services to determine physical or mental defects and 2) healthcare, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (CFR 440.40 (b)). EPSDT requirements help to ensure access to all medically necessary health services within the federal definition of "medical assistance".

Dental Benefit Program Request for Proposals

E-Consultation - The use of electronic computing and communication technologies in consultation processes.

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

Eligibility Determination - The process by which an individual may be determined eligible for the Medicaid or Medicaid-expansion CHIP program.

Eligible - An individual determined eligible for assistance in accordance with the Medicaid State Plan(s) under Title XIX (Medicaid) or Title XXI (CHIP) of the Social Security Act.

Emergency Dental Condition – a dental or oral condition that requires immediate services for relief of symptoms and stabilization of the condition; such conditions include severe pain; hemorrhage; acute infection; traumatic injury to the teeth and surrounding tissue; or unusual swelling of the face or gums.

Emergency Dental Services – Those services necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structures (periodontal membrane, gingival, alveolar bone), jaws, and tissue of the oral cavity.

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

Emergency Services – Covered outpatient services that are furnished by a provider that is qualified to furnish these services under 42 CFR 438.114(a) and 1932(b)(2) and that are needed to screen, evaluate, and stabilize an emergency medical condition. Services defined as such under Section 1867 (e) of the Social Security Act (“anti-dumping provisions”). If an emergency medical condition exists, the Health Plan is obligated to pay for the emergency service. Coverage of emergency services must not include any prior authorization requirements and the “prudent layperson” standard shall apply to both in-plan and out-of-plan coverage.

Encounter - A distinct set of healthcare services provided to a Medicaid member enrolled with the Health Plan on the dates that the services were delivered.

Encounter Data - Healthcare encounter data include: (i) All data captured during the course of a single healthcare encounter that specify the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the member receiving services during the encounter; (ii) The identification of the member receiving and the provider(s) delivering the healthcare services during the single encounter; and, (iii) A unique, i.e. unduplicated, identifier for the single encounter..

Encounter Data Adjustment - Adjustments to encounter data that are allowable under the Medicaid Management Information System (MMIS) for HCFA 1500, UB 92, KM-3 and NCPDP version 3.2 claim forms as specified in the DBP Systems Companion Guide.

Enrollee – Louisiana Medicaid or CHIP recipient who is currently enrolled in the DBP.

Enrollment - The process conducted by the Health Plan by which an eligible Medicaid recipient becomes a member.

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

Excluded Services - those services which members may obtain under the Louisiana Medicaid State Plan and for which the Health Plan is not financially responsible.

Dental Benefit Program Request for Proposals

Expanded Services - A covered service provided by the Health Plan which is currently a non-covered service(s) in the Medicaid State Plan or is an additional Medicaid covered service furnished by the Health Plan to Medicaid DBP members for which the Health Plan receives no additional capitated payment, and is offered to members in accordance with the standards and other requirements set forth in the RFP.

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

External Quality Review (EQR) - The analysis and evaluation by an external quality review organization of aggregated information on quality, timeliness, and access to the healthcare services that the Health Plan or its subcontractors furnish to members and to DHH.

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

Federal Financial Participation (FFP) – This is also known as federal match; the percentage of federal matching dollars available to a state to provide Medicaid and CHIP services. The federal Medical Assistance Percentage (FMAP) is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.

Federally Qualified Health Center (FQHC) - An entity that receives a grant under Section 330 of the Public Health Service Act, as amended (Also see Section 1905(1)(2)(B) of the Social Security Act) to provide primary healthcare and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.

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

FFS Provider - An institution, facility, agency, person, corporation, partnership, or association approved by DHH which accepts payment in full for providing benefits, with the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

Fiscal Intermediary (FI) - DHH's designee or agent responsible in the current delivery model for an array of support services including MMIS development and support, claims processing, pharmacy support services, provider support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support.

Fiscal Year (FY) – Refer to budget year - Federal Fiscal Year (FFY): October 1 through September 30; State Fiscal Year (SFY): July 1 through June 30.

Fraud – As relates to Medicaid Program Integrity, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received.

Full-Time Equivalent Position (FTE) – Refers to the equivalent of one (1) individual full-time employee who works forty (40) hours per week; or a full-time primary care dentist shall be defined as a one delivering outpatient preventive and primary (routine, urgent and acute) care for twenty (20) hours or more per week (exclusive of travel time).

GEO Coding – Refers to the process in which implicit geographic data is converted into explicit or map-form images.

GEO Mapping - The process of finding associated geographic coordinates (often expressed as latitude and longitude) from other geographic data, such as street addresses, or zip codes (postal codes). With geographic coordinates the features can be mapped and entered into Geographic Information Systems, or the coordinates can be embedded into media.

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Geographic Service Area (GSA) - All the parishes included in any DHH-defined service area. Region “A” consists of DHH Administrative Regions 1 and 9. Region “B” consists of DHH Administrative Regions 2, 3 and 4. Region “C” consists of DHH Administrative Regions 5, 6, 7 and 8.

Go-Live Date – The date the Health Plan shall begin providing services to Medicaid members.

Grievance – An expression of member/provider dissatisfaction about any matter other than an action, as action is defined. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

Grievance Process – The process for addressing grievances

Grievance System – A grievance process, an appeal process, and access to the State Fair Hearing system. Any grievance system requirements apply to all three components of the grievance system not just the grievance process.

HIPAA Privacy Rule (45 CFR Parts 160 & 164) – This is the federal the standards for the privacy of individually identifiable health information.

HIPAA Security Rule (45 CFR Parts 160 & 164) – Part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which stipulates that covered entities must maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their Electronic Protected Health Information against any reasonably anticipated risks.

Healthcare Professional - A physician or other healthcare practitioner licensed, accredited or certified to perform specified health services consistent with state law. Other healthcare practitioner includes any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Healthcare Provider - A healthcare professional or entity that provides healthcare services or goods.

Healthcare Effectiveness Data and Information Set (HEDIS) - A set of performance measures developed by the National Committee for Quality Assurance (NCQA). The measures were designed to help healthcare purchasers understand the value of healthcare purchases and measure plan (e.g. Health Plan) performance.

Historical Provider Relationship - The provider who has been the main source of Medicaid services for the member during the previous year (decided by the provider (primary care dentist or dental specialist) in the previous 12 months with whom the member had the most visits).

Health Information Technology for Economic and Clinical Health Act (HITECH Act) Title IV - the secure electronic exchange and use of health information. The legislation establishes a transparent and open process for the development of standards that will allow for the nationwide electronic exchange of information between doctors, hospitals, patients, Health Plans, the government and others by the end of 2009. It establishes a voluntary certification process for health information technology products. The National Institute of Standards and Technology will provide for the testing of such products to determine if they meet the national standards that allow for the secure electronic exchange and use of health information.

ICD-9-CM codes – International Classification of Diseases, 9th Revision, Clinical Modification codes represent a uniform, international classification system of coding disease and injury diagnoses. This coding system arranges diseases and injuries into code categories according to established criteria. The Health Plan shall move to ICD-10-CM as it becomes effective.

Immediate – In an instant; instantly or without delay, but not more than 24 hours.

Implementation Date – The date DHH notifies the Health Plan that Network Adequacy has been certified by DHH, the Health Plan has successfully completed the Readiness Review and is approved to begin enrolling members.

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

Incurred But Not Reported (IBNR) - Services rendered for which claim/encounter has not been received by the Health Plan.

Individual Practice - Independent primary care dentists who work in their own private practices.

Individuals with Disabilities Education Act (IDEA) - A United States federal law that ensures services to children with disabilities throughout the United States. IDEA governs how states and public agencies provide early intervention, special education and related services to children with disabilities.

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

Inpatient Facility - Hospital or clinic for treatment that requires at least one overnight stay.

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

Institutionalized – A patient in a nursing facility; an in-patient in a medical institution or institution for mental disease, whereby payment is based on a level of care provided in a nursing facility; or receives home and community-based waiver services.

Investigational Procedure/Service – See Experimental Procedure/Service.

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

LaCHIP – Refers to the Louisiana's Medicaid expansion CHIP (Title XXI) Program that provides health coverage to uninsured children under age 19, whose families have a net income up to 200 percent of the Federal Poverty Level (FPL); and whose income exceeds the Medicaid limit. Phase I includes children ages 6-18 with income from 100% up to and including 133% FPL; Phase II includes children with income from 134% up to and including 150% FPL; Phase III includes children with income from 151% FPL up to and including 200% FPL.

Louisiana Children's Health Insurance Program (LaCHIP) – Louisiana's name for the Children's Health Insurance Plan created by Title XXI of the Social Security Act in 1997. Provides health coverage to uninsured children under age 19, whose families have a net income up to 200 percent of the Federal Poverty Level (FPL); and whose income exceeds the Medicaid limit. Phase I includes children ages 6-18 with income from 100% up to and including 133% FPL; Phase II includes children with income from 134% up to and including 150% FPL; Phase III includes children with income from 151% FPL up to and including 200% FPL; and a separate state CHIP program for the unborn prenatal option and for children with income from 200% up to and including 250% FPL.

Louisiana Department of Health and Hospitals (DHH) – The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Louisiana.

Louisiana's Health Insurance Premium Payment Program (LaHIPPP) - Louisiana Medicaid program that pays for some or all of the health insurance premiums for an employee and their family if they have insurance available through their job and someone in the family is enrolled in Medicaid.

Louisiana Medicaid State Plan – The binding written agreement between DHH and CMS which describes how the Medicaid program is administered and determines the services for which DHH will receive federal financial participation.

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Major Subcontract - means any contract, subcontract, or agreement between the Health Plan and another entity that meets any of the following criteria:

- the other entity is an affiliate of the Health Plan;
- the subcontract is considered by DHH to be for a key type of service or function, including:
 - administrative services (including but not limited to third party administrator, network administration, and claims processing);
 - delegated networks (including but not limited to vision)
 - management services (including management agreements with parent)
 - reinsurance;
 - disease management;
 - call lines (including nurse and medical consultation); or
 - Any other subcontract that is, or is reasonably expected to be, more than \$100,000 per year. Any subcontracts between the Health Plan and a single entity that are split into separate agreements by time period, GSA, etc., will be consolidated for the purpose of this definition.

For the purposes of this RFP, major subcontracts do not include contracts with any non-affiliates for any of the following, regardless of the value of the contract: utilities (e.g., water, electricity, telephone, Internet), mail/shipping, office space, or computer hardware.

Major Subcontractor - Means any entity with a major subcontract with the Health Plan. For the purposes of this Contract, major subcontractors do not include providers in the Health Plan's provider network. Major subcontractors may include, without limitation, affiliates, subsidiaries, and affiliated and unaffiliated third parties.

Marketing - Means any communication, from the Health Plan to a Medicaid enrollee who is not enrolled in the Health Plan, that can reasonably be interpreted as intended to influence the recipient to enroll in the Health Plan.

Marketing Materials - Information produced in any medium, by or on behalf of the Health Plan that can reasonably be interpreted as intended to market to potential enrollees or enrollees.

Mass Media - A method of public advertising that can create Health Plan name recognition among a large number of Medicaid recipients and can assist in educating them about potential healthcare choices. Examples of mass media are radio spots, television advertisements, newspaper advertisements, newsletters, and video in doctor's office waiting rooms.

Material Change - Material changes are changes affecting the delivery of care or services provided under this RFP. Material changes include, but are not limited to, changes in composition of the provider network, subcontractor network, the Health Plan's complaint and grievance procedures; healthcare delivery systems, services, changes to expanded services; benefits; geographic service area; enrollment of a new population; procedures for obtaining access to or approval for healthcare services; any and all policies and procedures that required DHH approval prior to implementation; and the Health Plan's capacity to meet minimum enrollment levels. DHH shall make the final determination as to whether a change is material.

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

Medicaid - A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act Amendment. Medicaid offers federal matching funds to states for costs incurred in paying healthcare providers for serving covered individuals.

Medicaid Eligibility Office - DHH offices located within select parishes of the state and centralized State Office operations that are responsible for initial and ongoing Medicaid financial eligibility determinations.

Medicaid Eligible - Refers to an individual determined eligible, pursuant to federal and state law, to receive medical care, goods and services for which DHH may make payments under the Medicaid or CHIP Programs, who is enrolled in the Medicaid or CHIP Program, and on whose behalf payments may or may not have been made.

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Medicaid FFS Provider - An institution, facility, agency, person, corporation, partnership, or association that has signed a PE 50 agreement, been approved by DHH, and accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

Medicaid Management Information System (MMIS) – Mechanized claims processing and information retrieval system which all states Medicaid programs are required to have and which must be approved by the Secretary of DHHS. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Enrollees.

Medicaid Recipient – An individual who has been determined eligible, pursuant to federal and state law, to receive medical care, goods or services for which DHH may make payments under the Medicaid or CHIP Program, who is or may not be currently enrolled in the Medicaid or CHIP Program, and on whose behalf payment is made.

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

Medical Loss Ratio – The percentage of PMPM payments received by the Health Plan from DHH used to pay medical claims from providers and approved quality improvement and IT costs.

Medical Loss Ratio Year—The calendar year for which Medical Loss Ratio is being reported.

Medical Record - A single complete record kept at the site of the member's treatment(s), which documents, medical or allied goods and services, including, but not limited to, outpatient and emergency medical healthcare services whether provided by the Health Plan, its subcontractor, or any out-of-network providers. The records may be electronic, paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 CFR 456.111 and 42 CFR 456.211.

Medical Vendor Administration (MVA) – Refers to the name for the budget unit specified in the Louisiana state budget that contains the administrative component of the Bureau of Health Services Financing (Louisiana's single state Medicaid agency).

Medically Necessary Services - Those healthcare services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and 2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

The Medicaid Director, in consultation with the Medicaid Dental Director, may consider authorizing services at his discretion on a case-by-case basis.

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

Member – As it relates to the Louisiana Medicaid Program and this RFP, refers to a Medicaid or CHIP eligible who enrolls in the Health Plan under the provisions of this RFP and also refers to "enrollee" as defined in 42 CFR 438.10(a).

Member Materials - Means all written materials produced or authorized by the Health Plan and distributed to members or potential members containing information concerning the DBP. Member materials include, but are not limited to, member ID cards, member handbooks, provider directories, and marketing materials.

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Member Month – A month of coverage for a Medicaid eligible who is enrolled in the Health Plan.

Methodology- The planned process, steps, activities or actions taken by the Health Plan to achieve a goal or objective, or to progress toward a positive outcome.

Monetary Penalties – Monetary sanctions that may be assessed whenever the Health Plan, its providers, and/or its subcontractors fail to achieve certain performance standards and other items defined in the terms and conditions of the Contract.

Monitoring - The process of observing, evaluating, analyzing and conducting follow-up activities.

Must – Denotes a mandatory requirement.

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

National Response Framework - Part of the Federal Emergency Management Agency (FEMA), The National Response Framework presents the guiding principles that enable all response partners to prepare for and provide a unified national response to disasters and emergencies. The framework establishes a comprehensive, national, all-hazards approach to domestic incident response.

Network – As utilized in the RFP, “network” may be defined as a group of participating providers linked through subcontractual arrangements to the Health Plan to supply a range of primary and acute healthcare services. Also called Provider Network.

Network Adequacy - Refers to the network of healthcare providers for the Health Plan that is sufficient in numbers and types of providers and facilities to ensure that all services are accessible to members without unreasonable delay. Adequacy is determined by a number of factors, including but not limited to, provider patient ratios; geographic accessibility and travel distance; waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments and hours of provider operations.

Non-Covered Services - Services not covered under the Title XIX Louisiana State Medicaid Plan.

Non-Emergency - An encounter by a Health Plan member who has presentation of medical signs and symptoms, to a healthcare provider

Non-Emergency Medical Transportation (NEMT) - A ride, or reimbursement for a ride, provided so that a member with no other transportation resources can receive services from a medical provider. NEMT does not include transportation provided on an emergency basis, such as trips to the emergency room in life threatening situations.

Non-Participating Physician - A physician licensed to practice that has not contracted with or is not employed by the Health Plan to provide healthcare services.

Non-Urgent Sick Care – Medical care given for an acute onset of symptoms that is not emergent or urgent in nature. Examples of non-urgent sick visit include cold symptoms, sore throat, and nasal congestion; requires face-to-face medical attention within 48-72 hours of member notification of a non-urgent condition, as clinically indicated.

Nurse Practitioner (NP) - An advanced practice registered nurse educated in a specified area of care and certified according to the requirements of a nationally recognized accrediting agency such as the American Nurses Association’s American Nurses Credentialing Center, National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties, or the National Certification Board of Pediatric Nurse Practitioners and Nurses, or as approved by the state board of nursing and who is authorized to provide primary, acute, or chronic care, as an advanced nurse practitioner acting within his/her scope of practice to individuals, families, and other groups in a variety of settings including, but not limited to, homes, institutions, offices, industry, schools, and other community agencies.

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Open Panel - means primary care dentists who are accepting new patients for the Louisiana Medicaid DBP.

Operational Start Date - Means the first day on which the Health Plan is responsible for providing core benefits and services to DBP members and all related Contract functions. The Operational Start Date applicable to this Contract is set forth in the Contract between DHH and the Health Plan (Attachment C of this RFP).

Original: Denotes must be signed in ink

Out-of-Network (OON) Provider - means an appropriately licensed individual, facility, agency, institution, organization or other entity that has not entered into a contract with the Health Plan for the delivery of covered services to the Health Plan's members.

Ownership Interest - The possession of stock, equity in the capital, or any interest in the profits of the Health Plan, for further definition see 42 CFR 455.101 (2005).

Per Member Per Month (PMPM) – The amount of money paid or received on a monthly basis for each individual enrolled in the Health Plan.

Performance Concern - The informal documentation of an issue. The Health Plan is required to respond to the performance concern by defining a process to detect, analyze and eliminate non-compliance and potential causes of non-compliance. This is a “warning” and failure to comply with the Corrective Action Plan and/or continued non-compliance may result in formal action against the Health Plan.

Performance Improvement Projects (PIP) – Projects to improve specific quality performance measures through ongoing measurements and interventions that result in significant improvement, sustained over time, with favorable effect on health outcomes and member satisfaction.

Performance Measures – Specific operationally defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement related important dimensions of care and service.

Personal Health Record (PHR) – A health record that is initiated and maintained by an individual.

Pharmacy Benefits – For the purposes of this RFP and exclusion from core benefits and services, pharmacy benefits are defined as prescription drugs that are dispensed by pharmacies.

Plan of Care – Strategies designed to guide healthcare professionals involved with patient care. Such plans are patient specific and are meant to address the total status of the patient. Care plans are intended to ensure optimal outcomes for patients during the course of their care.

PMPM Rate - The per-member, per-month rate paid to the Health Plan by DHH for the provision of medical services to DBP members.

Policies - The general principles by which DHH is guided in its management of the Title XIX program, and as further defined by DHH promulgations and by state and federal rules and regulations.

Post-Stabilization Care Services - Covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain, improve or resolve the member's condition pursuant to 42 CFR 422.113(c) and 42 CFR 438.114(e).

Potential Enrollee - A Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in the Health Plan, but is not yet an enrollee of the Health Plan.

Prepaid Ambulatory Health Plan (PAHP) – A entity that provides medical services to members under contract with the State agency, on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates and does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its members and does not have a comprehensive risk contract.

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Prepaid Model - A method of paying the Health Plan for the cost of healthcare services in advance of their use. A method providing in advance for the cost of predetermined benefits for a population group, through regular periodic payments in the form of premiums, dues, or contributions.

Preventive Care – Refers to the treatment to avert disease/illness and/or its consequences. The term is used to designate prevention and early detection programs rather than restorative or treatment programs. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred; requires a face-to-face visit within 4 weeks of member request.

Primary Care Dentist - A Medicaid DBP staff or subcontracted dentist practicing as a general or family practitioner, pediatric dentist, or other specialty approved by the Agency, who furnishes primary dental care and dental patient management services to a member.

Primary Care Services - Healthcare services and laboratory services customarily furnished by or through a primary care dentist for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion either through, direct service to the member when possible, or through appropriate referral to specialists and/or ancillary providers.

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

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

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

Provider – Either (1) for the FFS program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the Health Plan, any individual or entity that is engaged in the delivery of healthcare services and is legally authorized to do so by the state in which it delivers services.

Provider Appeal - The formal mechanism which allows a provider the right to appeal a Health Plan final decision.

Provider Complaint - A verbal or written expression by a provider which indicates dissatisfaction or dispute with Health Plan policy, procedure, claims processing and/or payment, or any aspect of Health Plan functions.

Provider Directory - A listing of healthcare service providers under contract with the Health Plan that is prepared by the Health Plan as a reference tool to assist members in locating providers that are available to provide services.

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

Provider Subcontract - An agreement between the Health Plan and a provider of services to furnish core benefits and services to members, or with a marketing organization, or with any other organization or person who agrees to perform any administrative function or service for the Health Plan specifically related to fulfilling the Health Plan's obligations under the terms of this RFP.

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

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

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Quality Assessment and Performance Improvement (QAPI) Plan – A written plan, required of the Health Plan, detailing quality management and committee structure, performance measures, monitoring and evaluation process and improvement activities measures that rely upon quality monitoring implemented to improve healthcare outcomes for enrollees.

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

Quality Management (QM) – The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge.

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

Readmission - Subsequent admissions of a patient to a hospital or other healthcare institution for treatment.

Recipient - An individual entitled to benefits under Title XIX or Title XXI of the Social Security Act, and under the Louisiana Medicaid State Plan who is or was enrolled in Medicaid and on whose behalf a payment has been made for medical services rendered.

Redacted Proposal – The removal of confidential and/or proprietary information from one copy of the proposal for public records purposes.

Referral Services - Healthcare services provided to DBP members to both in-and out-of-network when ordered and approved by the Health Plan, including, but not limited to in-network specialty care and out-of-network services which are covered under the Louisiana Medicaid State Plan.

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

Reinsurance – Insurance the Health Plan purchases to protect itself against part or all of the losses incurred in the process of honoring the claims of members; also referred to as “stop loss” insurance coverage.

Related Party - A party that has, or may have, the ability to control or significantly influence a contractor/subcontractor, or a party that is, or may be, controlled or significantly influenced by a contractor/subcontractor. "Related parties" include, but are not limited to, agents, management employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

Relationship - A director, officer, or partner of the Health Plan; a person with beneficial ownership of five percent or more of the Health Plan’s equity; or a person with an employment, consulting or other arrangement (e.g., providers) with the Health Plan obligations under its contract with the state.

Remittance Advice – An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only. Transactions may include but are not limited to, members enrolled in the Health Plan, payments for maternity, and adjustments.

Representative - Any person who has been delegated the authority to obligate or act on behalf of another. Also known as the authorized representative.

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Reprocessing (Claims) - Upon determination of the need to correct the outcome of one or more claims processing transactions, the subsequent attempt to process a single claim or batch of claims. **RFP (Request for Proposals)** – As relates to DBP, the process by which DHH invites proposals from interested parties for the procurement of specified services.

Responsible Party – An individual, often the head of household, who is authorized to make decisions and act on behalf of the Medicaid recipient. This is the same individual that completes and signs the Medicaid application on behalf of a covered individual, agreeing to the rights and responsibilities associated with Medicaid coverage.

Risk - The chance or possibility of loss. The member is at risk only for pharmacy copayments as allowed in the Medicaid State Plan and the cost of non-covered services.

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

Routine Dental Care – a well care (non-acute) dental visit for preventive services (e.g. screening, cleaning, check-up, evaluation) or follow up to a previously treated condition and any other routine visit for other than the treatment of a dental illness/condition (e.g. sick care).

Rural Area – Refers to any parish within a Geographic Service Area that meets the Office of Management and Budget definition of rural. (See Appendix BB for map of Louisiana Rural Parishes)

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

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

Secondary Care - Healthcare services provided by medical specialists who generally do not have first contact with patients, but instead are referred to them by primary care dentists.

Section 1931 - Category of Medicaid eligibility for low-income parents who do not receive cash assistance but whose income is below Louisiana's 1996 Aid to Families with Dependent Children income threshold. Louisiana's name for this program is Low Income Families with Children (LIFC).

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

Service Area – the entire State of Louisiana is the service area

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

Shall - Denotes a mandatory requirement.

Should, May, Can - Denotes a preference but not a mandatory requirement.

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

Significant Traditional Provider (STP) - Those Medicaid enrolled providers that provided the top eighty percent (80%) of Medicaid services for the DBP-eligible population in the base year of 2010.

Social Security Act - The current version of the Social Security Act of 1935 (42 U.S.C.A. § 301 et seq.) as amended which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI).

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Solvency - The minimum standard of financial health for the Health Plan where assets exceed liabilities and timely payment requirements can be met.

Span of Control – Information systems and telecommunications capabilities that the Health Plan itself operates or for which it is otherwise legally responsible according to the terms and conditions with DHH. The span of control also includes systems and telecommunications capabilities outsourced by the Health Plan.

Special Healthcare Needs Population - An individual of any age with a mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized healthcare requirements.

Specialist/Specialty Services - A physician whose practice is limited to a particular branch of medicine or surgery, including one who, by virtue of advanced training is certified by a specialty board as being qualified to so limit his practice.

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

Start-Up Date – The date Health Plan providers begin providing medical care to their Medicaid members. Also referred to as operations start date and “go-live date.”

State - The state of Louisiana.

State Plan – Refers to the Louisiana Medicaid State Plan.

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

Subcontractor - A person, agency or organization with which the Health Plan has subcontracted or delegated some of its management functions or other contractual responsibilities to provide covered services to its members.

Subsidiary - Means an affiliate controlled by such person or entity directly or indirectly through one (1) or more intermediaries.

Subspecialist Services - See Specialty Services

Supplemental Security Income (SSI) – A federal program which provides a cash benefit to people who are aged, blind or disabled and who have little or no income or assets Louisiana is a “Section 1634” state and anyone determined eligibility for SSI is automatically eligible for Medicaid.

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

- Record Search Time-the time elapsed after the search command is entered until the list of matching records begins to appear on the monitor.
- Record Retrieval Time-the time elapsed after the retrieve command is entered until the record data begin to appear on the monitor.
- Print Initiation Time- the elapsed time from the command to print a screen or report until it appears in the appropriate queue.
- On-line Claims Adjudication Response Time- the elapsed time from the receipt of the transaction by the Health Plan from the provider and/or switch vendor until the Health Plan hands-off a response to the provider and/or switch vendor.

System Unavailability – Measured within the Health Plan’s information system span of control. A system is considered not available when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the “enter” or other function key.

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

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Targeted Case Management – Case management for a targeted population of persons with special needs described in the Louisiana Medicaid State Plan.

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

Third Party Liability (TPL) - Refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan.

Timely – Existing or taking place within the designated period; within the time required by statute or rules and regulations, contract terms, or policy requirements.

Title IV-E - Section of the Social Security Act of 1935 as amended that encompasses medical assistance for foster children and adoption assistance.

Title V – Section of the Social Security Act of 1935 as amended that encompasses maternal child health services.

Title X - Section of the Social Security Act of 1935 as amended that encompasses and governs family planning services.

Title XIX – Section of the Social Security Act of 1935, as amended, that encompasses and governs the Medicaid Program.

Title XXI - Section of the Social Security Act of 1935, as amended, that encompasses and governs the Children’s Health Insurance Program (CHIP).

Transition Phase - includes all activities the Health Plan is required to perform between the Contract effective date and the implementation date

Turnover Phase – includes all activities the Health Plan is required to perform in conjunction with the end of the Contract.

Turnover Plan - means the written plan developed by the Health Plan, approved by DHH, to be employed during the turnover phase.

Urgent Care - Medical care provided for a condition that without timely treatment, could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily function, or cause the development of a chronic illness or need for a more complex treatment. (Examples of conditions that require urgent care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, suspected fracture; urgent care requires timely face-to-face medical attention within 24 hours of member notification of the existence of an urgent condition.

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

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

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

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

Waiting Time(s) – Time spent both in the lobby and in the examination room prior to being seen by a provider.

Waiver - Medicaid Section 1915(c) Home and Community Based Services (HCBS) programs which in Louisiana are New Opportunities Waiver (NOW), Children’s Choice, Adult Day Healthcare (ADHC), Elderly Disabled and Adult (EDA), Supports Waiver, Residential Options Waiver (ROW), and any other 1915(c) waiver that may be implemented.

Week - The DHH seven-day week, Monday through Sunday.

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Will - Denotes a mandatory requirement.

Willful – Refers to conscious or intentional but not necessarily malicious act.

25. Acronyms

ADA – American Dental Association

ADA – Americans with Disabilities Act

BHSF – Bureau of Health Services Financing

CAH – Critical Access Hospital

CAHPS – The Consumer Assessment of Health Providers and Systems

CAP – Corrective Action Plan

CDC – Centers for Disease Control and Prevention

CDT – Current Dental Terminology

CFR – Code of Federal Regulations

CHIP – Children’s Health Insurance Program

CMS – Centers for Medicare and Medicaid Services

COB – Coordination of Benefits

CPT – Current Procedural Terminology

DBP – Dental Benefit Program

DBPM – Dental Benefit Program Manager

DHH – Department of Health and Hospitals

DHHS – Department of Health and Humans Services (also HHS)

DM – Disease Management

DOI – Louisiana Department of Insurance

EHR – Electronic Health Records

EPSDT - Early and Periodic Screening, Diagnosis and Treatment

EQR – External Quality Review

EQRO - External Quality Review Organization

FDA – Food and Drug Administration

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FFP – Federal Financial Participation

FFS – Fee for Service

FI – Fiscal Intermediary

FQHC – Federally Qualified Health Center

FTE – Full-Time Equivalent

FY – Fiscal Year

GSA – Geographic Service Area

HCBS – Home and Community Based Services Waiver

HCFA – Healthcare Financing Administration

HEDIS – Healthcare Effectiveness Data and Information Set

HHS – United States Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act

HITECH – Health Information Technology for Economic and Clinical Health Act

HMO – Health Management Organization

IBNR – Incurred But Not Reported

IDEA – Individuals with Disabilities Education Act

INS – U.S. Immigration and Naturalization Services

IS – Information Systems

LaCHIP – Louisiana Children’s Health Insurance Program

LaHIPPP – Louisiana Health Insurance Premium Payment Program

LIFC – Low Income Families and Children

MLR – Medical Loss Ratio

MMIS – Medicaid Management Information System

MVA – Medical Vendor Administration

NAIC – National Association of Insurance Commissioners

NCQA – National Committee for Quality Assurance

NEMT – Non-Emergency Medical Transportation

NP – Nurse Practitioner

NPI – National Provider Identifier

OON – Out of Network Provider

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PAHP - Prepaid Ambulatory Health Plan

PCCM – Primary Care Case Manager

PCD – Primary Care Dentist

PCS – Personal Care Services

PHI – Personal Health Information

PHR – Personal Health Record

PIP – Performance Improvement Projects

PMPM – Per Member, Per Month

PPC – Provider Preventable Condition

PPS –Prospective Payment System

QAPI –Quality Assessment and Performance Improvement Plan

QM – Quality Management

RFP – Request for Proposals

RHC – Rural Health Clinic

RN – Registered Nurse

SBHC – School Based Health Center

SFTP – Secure File Transfer Protocol

SSA – Social Security Act

SSI – Supplemental Security Income

STP – Significant Traditional Provider

TANF –Temporary Assistance for Needy Families

TPL – Third Party Liability

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

UM – Utilization Management

UR – Utilization Review

26. List of Appendices to RFP

- Appendix A – Map of Parishes within Each GSA
- Appendix B – Summary of Required Providers
- Appendix C – Letter of Intent (LOI)
- Appendix D – MLR (Medical Loss Ratio) Calculation Methodology
- Appendix E – Louisiana Medicaid State Plan Services
- Appendix F– Dental Benefit Plan Performance Measures
- Appendix G – Health Plan Subcontract Requirements
- Appendix H– Health Plan Data Use Agreement
- Appendix I – Requirements for Health Plan Physician Incentive Plans
- Appendix J – Provider’s Bill of Rights
- Appendix K – Reserved
- Appendix L – Fiscal Intermediary (FI) Payment Schedule
- Appendix M – DHH Marketing and Member Education Materials Approval Form
- Appendix N– DHH Event Submission Form
- Appendix O – Dental Services Manual
- Appendix P– DHH Marketing Complaint Form
- Appendix Q – Member’s and Potential Member’s Bill of Rights
- Appendix R – Marketing Plan Monthly Report
- Appendix S – Grievance, Appeal and State Fair Hearing Report
- Appendix T – Performance Improvement Projects
- Appendix U– Coordination of Health Plan Fraud and Abuse Complaints and Referrals
- Appendix V –Network Provider and Subcontractor Listing
- Appendix W – Health Plan Disenrollment Report -- *To Be Established*
- Appendix X – EPSDT Reporting
- Appendix Y– Model Attestation Letter for Reports
- Appendix Z – Transition Period Requirements
- Appendix AA –Proposal Submission and Evaluation Documents
- Appendix BB – Louisiana Rural Parishes Map

Appendix CC– Attestation of Provider Network Submission

Appendix DD– Person First Policy

Appendix EE– Provider Incentive Payments Template

Appendix FF – Reference Questionnaire

Appendix GG – Added Value

27. List of DBP Companion Guides

1. Financial Reporting Companion Guide
2. State Fair Hearing Companion Guide
3. Marketing Companion Guide
4. Systems Companion Guide
5. Bayou Health Quality Companion Guide

28. Attachments

- A. Veteran and Hudson Initiatives
- B. Certification Statement
- C. DHH Standard Contract Form (CF-1)
- D. HIPAA BAA
- E. Cost and Pricing Template

**Minimum Required Language - Request For Proposal (RFP)
Veteran-Owned and Service-Connected Small Entrepreneurships (Veteran Initiative) and Louisiana Initiative for Small
Entrepreneurships (Hudson Initiative) Programs**

Participation of Veteran Initiative and Hudson Initiative small entrepreneurships will be scored as part of the technical evaluation.

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.louisianaforward.com/index_2.asp.

Ten percent (10%) of the total evaluation points on this RFP are reserved for proposers who are themselves a certified Veteran or Hudson Initiative small entrepreneurship or who will engage the participation of one or more certified Veteran or Hudson Initiatives small entrepreneurships as subcontractors.

Reserved points shall be added to the applicable proposers' evaluation score as follows:

Proposer Status and Reserved Points

- Proposer is a certified small entrepreneurship: Full amount of the reserved points
- Proposer is not a certified small entrepreneurship but has engaged one or more certified small entrepreneurships to participate as subcontractors or distributors. Points will be allocated based on the following criteria:
 - the number of certified small entrepreneurships to be utilized
 - the experience and qualifications of the certified small entrepreneurship(s)
 - the anticipated earnings to accrue to the certified small entrepreneurship(s)

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.

The statutes (R.S. 39:2171 *et. seq.*) concerning the Veteran Initiative may be viewed at <http://legis.la.gov/lss/lss.asp?doc=671504>; and the statutes (R.S. 39:2001 *et. seq.*) concerning the Hudson Initiative may be viewed <http://legis.la.gov/lss/lss.asp?doc=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 <http://www.doa.louisiana.gov/osp/se/se.htm>.

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.louisianaforward.com/index_2.asp. 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 may be accessed from the State of

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Louisiana Procurement and Contract (LaPAC) Network <http://wwwprd.doa.louisiana.gov/osp/lapac/vendor/srchven.asp>. 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.

Rev. 12/1/11

PROPOSAL CERTIFICATION STATEMENT
RFP # 305PUR-DHHRFP-DBP- MVA

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

- 1. **OFFICIAL CONTACT:** DHH 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: (Type or 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 DHH 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 accepts the procedures, evaluation criteria, contract terms and conditions, and all other administrative requirements set forth in this RFP;
- 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 quote is valid for at least 120 days from the date of proposal's signature below;
- 5. Proposer understands that if selected as the successful Proposer, he/she will have seven (7) business days from the date of delivery of initial contract in which to complete contract negotiations, if any, and execute the final contract document. DHH 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 \$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 OMB Circular A-133. (A list of parties who have been suspended or debarred can be viewed via the internet at www.epls.gov).

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Authorized Signature: _____

Typed or Printed Name: _____

Title: _____

Company Name: _____

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CFMS: DHH: AGENCY #: 305

Attachment C
DHH - CF - 1

**CONTRACT BETWEEN STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Medical Vendor Administration**

AND

FOR

Personal Services Professional Services Consulting Services Social Services

9) **Brief Description Of Services To Be Provided:**

Contractor shall provide a broad range of services necessary for the delivery of oral healthcare services to Medicaid enrollees participating in the Medicaid Dental Benefit Program (DBP), utilizing the most cost effective manner. Such services include developing and maintaining an adequate provider network, access standards, utilization management, quality management, prior authorization, provider monitoring, member and provider services, primary care management, fraud and abuse monitoring and compliance, case management, and account management. This contract includes such duties as 24/7 access to a oral health care professional, service authorization, provider payments, claims management, marketing and member education. See Statement of Work.

12) This contract may be terminated by either party upon giving thirty (30) days advance written notice to the other party with or without cause but in no case shall continue beyond the specified termination date.

13) **Maximum Contract Amount**

14) **Terms of Payment**

DHH shall make monthly capitated payments for each member enrolled into the DBP. The DBP shall agree to accept, as payment in full, the actuarially sound rate approved by DHH pursuant to the contract, and shall not seek additional payment from a member, or DHH, for any unpaid cost. DHH reserves the right to defer remittance of the PMPM payment for June until the first Medicaid Management Information System (MMIS) payment cycle in July to comply with state fiscal policies and procedure.

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**PAYMENT WILL BE MADE
ONLY UPON APPROVAL OF:**

Name

Title

Phone Number

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

Dental Benefit Program Request for Proposals

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

1. Contractor hereby agrees to adhere as applicable to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Americans with Disabilities Act of 1990 as amended; the Rehabilitation Act of 1973 as amended; Sec. 202 of Executive Order 11246 as amended, and all applicable requirements imposed by or pursuant to the regulations of the U. S. Department of Health and Human Services. Contractor agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, color, religion, sex, age, national origin, handicap, political beliefs, disabled veteran, veteran status, or any other non-merit factor.
2. Contractor shall abide by the laws and regulations concerning confidentially which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of the Department, confidentiality rules and facility access procedures.)
3. The State Legislative Auditor, Office of the Governor, Division of Administration, and Department Auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this contract during the contract and for a three year period following final payment. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor, Department of Health and Hospitals, and Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.

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

4. Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit or copy records at the contractor's site, without expense to the Department.
5. Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from the Department under this contract may be assigned to a bank, trust company or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the Department and the Division of Administration, Office of Contractual Review.
6. Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this contract shall be Contractor's. The contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds, and shall maintain, at Contractor's expense, all necessary insurance for its employees, including but not limited to automobile insurance, workers' compensation and general liability insurance.
7. Contractor shall obtain and maintain during the contract term all necessary insurance including automobile insurance, workers' compensation insurance, and general liability insurance. The required insurances shall protect the Contractor, the Department of Health and Hospitals, and the State of Louisiana from all claims related to Contractor's performance of this contract. Certificates of Insurance shall be filed with the Department for approval. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days advance written notice to the Department. Commercial General Liability Insurance shall provide protection

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during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as claims for property damages, with combined single limits prescribed by the Department.

8. In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations. The contract contains a maximum compensation which shall be inclusive of all charges including fees and travel expenses.
9. No funds provided herein shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition or matter having the effect of law being considered by the legislature or any local governing authority. Contracts with individuals shall be exempt from this provision.
10. Should contractor become an employee of the classified or unclassified service of the State of Louisiana during the effective period of the contract, Contractor must notify his/her appointing authority of any existing contract with State of Louisiana and notify the contracting office of any additional state employment. This is applicable only to contracts with individuals.
 11. All non-third party software and source code, records, reports, documents and other material delivered or transmitted to Contractor by State shall remain the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract. All non-third party software and source code, records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract.
 12. Contractor shall not enter into any subcontract for work or services contemplated under this contract without obtaining prior written approval of the Department. Any subcontracts approved by the Department shall be subject to conditions and provisions as the Department may deem necessary; provided, however, that notwithstanding the foregoing, unless otherwise provided in this contract, such prior written approval shall not be required for the purchase by the contractor of supplies and services which are incidental but necessary for the performance of the work required under this contract. No subcontract shall relieve the Contractor of the responsibility for the performance of contractual obligations described herein.
 13. No person and no entity providing services pursuant to this contract on behalf of contractor or any subcontractor is prohibited from providing such services by the provisions of R.S. 42:1113 as amended in the 2008 Regular Session of the Louisiana Legislature.
 14. No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by the Department. In the event the Department determines that certain costs which have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, the Department shall have the right to set off and withhold said amounts from any amount due the Contractor under this contract for costs that are allowable.
 15. This contract is subject to and conditioned upon the availability and appropriation of Federal and/or State funds; and no liability or obligation for payment will develop between the parties until the contract has been approved by required authorities of the Department; and, if contract exceeds \$20,000, the Director of the Office of Contractual Review, Division of Administration in accordance with La. R.S. 39:1502.
 16. The continuation of this contract is contingent upon the appropriation of funds from the legislature to fulfill the requirements of the contract. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the

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Governor or by any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

17. Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of the Department; and, if contract exceeds \$20,000, approved by the Director of the Office of Contractual Review, Division of Administration. Budget revisions approved by both parties in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.
18. Any contract disputes will be interpreted under applicable Louisiana laws and regulations in Louisiana administrative tribunals or district courts as appropriate.
19. Contractor will warrant all materials, products and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against DHH, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in DHH's name, but at Contractor's expense and shall indemnify and hold harmless DHH against any loss, expense or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or other allied health providers solely for medical services.
20. Any equipment purchased under this contract remains the property of the Contractor for the period of this contract and future continuing contracts for the provision of the same services. Contractor must submit vendor invoice with reimbursement request. For the purpose of this contract, equipment is defined as any tangible, durable property having a useful life of at least (1) year and acquisition cost of \$1000.00 or more. The contractor has the responsibility to submit to the Contract Monitor an inventory list of DHH equipment items when acquired under the contract and any additions to the listing as they occur. Contractor will submit an updated, complete inventory list on a quarterly basis to the Contract Monitor. Contractor agrees that upon termination of contracted services, the equipment purchased under this contract reverts to the Department. Contractor agrees to deliver any such equipment to the Department within 30 days of termination of services.
21. Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, DHH, from all claims for damages, costs, expenses and attorney fees arising in contract or tort from this contract or from any acts or omissions of Contractor's agents, employees, officers or clients, including premises liability and including any claim based on any theory of strict liability. This provision does not apply to actions or omissions for which LA R.S. 40:1299.39 provides malpractice coverage to the contractor, nor claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (R.S. 13:5108.1(E)). Further it does not apply to premises liability when the services are being performed on premises owned and operated by DHH.
22. Any provision of this contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in State and Federal law, or applicable State or Federal regulations.
23. Contractor agrees that the current contract supersedes all previous contracts, negotiations, and all other communications between the parties with respect to the subject matter of the current contract.

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

HIPAA BUSINESS ASSOCIATE AGREEMENT

A. Purpose

The Louisiana Department of Health and Hospitals (Covered Entity) and DBP (Business Associate) agree to the terms of this Agreement for the purpose of protecting the privacy of individually identifiable health information under the Health Insurance Portability and Accountability Act of 1996, Public Law No. 104-191 ("HIPAA"), and regulations promulgated there under by the U.S. Department of Health and Human Services (the "HIPAA Regulations"); and Subtitle D of the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), also known as Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law No. 111-005 ("ARRA") in performing the functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract between the parties.

B. Definitions (Other terms used but not defined shall have the same meaning as those terms in the HIPAA Privacy Rule.)

1. Business Associate means the same as "business associate" in 45 CFR § 160.103.
2. Covered Entity means DHH.
3. Designated Record Set means the same as "designated record set" in 45 CFR § 164.501.
4. Individual means the same as "individual" in 45 CFR § 160.103 and includes a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
5. Privacy Rule means the HIPAA Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 160 and Part 164, Subparts A and E).
6. Protected Health Information (PHI) means the same as the term protected health information in 45 CFR § 160.103, limited to information received by Agency from Covered Entity.
7. Required By Law means the same as "required by law" in 45 CFR § 164.103, and other law applicable to the PHI disclosed pursuant to the Contract.
8. Secretary means the Secretary of the Department of Health and Hospitals or designee.
9. Security Standards shall mean the Security Standards at 45 C.F.R. Part 160 and Part 164, as may be amended.

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10. Electronic PHI shall have the same meaning as the term “electronic protected health information” in 45 C.F.R. § 160.103.
11. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system or its current meaning under 45 C.F.R. § 164.304.

C. Business Associate Provisions

Business Associate agrees to:

1. Not use or disclose PHI other than as permitted or required by the Contract or as required by law.
2. Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for in the Contract.
3. Mitigate to the extent practicable, any harmful effect known to Business Associate if it uses/discloses PHI in violation of the Contract.
4. Immediately report to Covered Entity any breaches in privacy or security that compromise PHI. Security and/or privacy breaches should be reported to:

Louisiana Department of Health and Hospitals
Bureau of Legal Services
Post Office Box 3836
Baton Rouge, Louisiana 70821
Phone: (225) 342-1112
Fax: (225) 342-2232

The Report should include a detailed description of the breach and any measures that have been taken by the Business Associate to mitigate the breach.

DHH may impose liquidated damages of \$300 per day from the date that the Business Associate knew or should have known of any breach in privacy or security that compromises PHI to the date that DHH becomes aware of the breach.

DHH may impose liquidated damages of up to \$25,000 for any breach in privacy or security that compromises PHI.

5. Ensure that any agent/contractor to whom it provides PHI agrees to the same restrictions/conditions that apply to the Business Associate in this Agreement.
6. If the Business Associate has PHI in a designated record set: (1) provide access at Covered

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Entity's request to PHI to Covered Entity or, as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR § 164.524; (2) make any amendment(s) to PHI in a designated record set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526.

7. Make its internal practices, books, records, and policies/procedures relating to the use/disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity, to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
8. Document Business Associate disclosures of PHI, other than disclosures back to Covered Entity, and related information as would be required for Covered Entity to respond to a request for an accounting of PHI disclosures in accordance with 45 CFR § 164.528.
9. Provide to Covered Entity or an individual, as designated by Covered Entity, information collected in accordance with Section C.8 of this Agreement, to permit Covered Entity to respond to a request for an accounting of PHI disclosures in accordance with 45 CFR § 164.528.
10. Encrypt all PHI stored on portable devices. Portable devices include all transportable devices that perform computing or data storage, manipulation or transmission including, but not limited to, diskettes, CDs, DVDs, USB flash drives, laptops, PDAs, Blackberrys, cell phones, portable audio/video devices (such as iPODs, and MP3 and MP4 players), and personal organizers.
11. Otherwise, not re-disclose Covered Entity PHI except as permitted by applicable law.
12. Be liable to Covered Entity for any damages, penalties and/or fines assessed against Covered Entity should Covered Entity be found in violation of the HIPAA Privacy Rule due to Business Associate's material breach of this section. Covered Entity is authorized to recoup any and all such damages, penalties and/or fines assessed against Covered Entity by means of withholding and/or offsetting such damages, penalties, and/or fines against any and all sums of money for which Covered Entity may be obligated to the Business Associate under any previous contract and/or this or future contracts. In the event there is no previous contractual relationship between the Business Associate and Covered Entity, the amount to cover such damages, penalties and/or fines shall be due from Business Associate immediately upon notice.

D. Permitted Uses and Disclosures by Business Associate

1. Except as limited in the Contract, Business Associate may use PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract,

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provided that such use would not violate the Privacy Rule if done by Covered Entity or Covered Entity's privacy practices. Unless otherwise permitted in this Agreement, in the Contract or required by law, Business Associate may not disclose/re-disclose PHI except to Covered Entity.

2. Except as limited in this Agreement, Business Associate may use/disclose PHI for internal management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, as needed for Business Associate to provide its services under the Contract.
3. Except as limited in this Agreement, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).
4. Business Associate may use PHI to report violations to appropriate Federal or State authorities as permitted by § 164.502(j)(1).

E. Covered Entity Provisions

Covered Entity agrees to:

1. Notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
2. Notify Business Associate of any changes in, or revocation of, permission by individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.
3. Notify Business Associate of any restriction to the use/disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use/disclosure of PHI.
4. Not request Business Associate to use/disclose PHI in any manner not permitted under the Privacy Rule if done by Covered Entity.

F. Term and Termination

1. The terms of this Agreement shall be effective immediately upon signing of both the Contract and this Agreement, and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is returned to Covered Entity, or, if it is infeasible to return PHI, protections are extended to such PHI in accordance with the termination provisions in this Section.

- a. Upon its knowledge of a material breach by Business Associate, Covered Entity shall either: Allow Business Associate to cure the breach or end the violation and terminate the Contract if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; or
- b. Immediately terminate the Contract if Business Associate has breached a material term of this Agreement and cure is not possible; or
- c. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

2. Effect of Termination

- a. Except as provided in paragraph (b) below, upon termination of the Contract, Business Associate shall return all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision also applies to PHI in the possession of Business Associate's contractors or agents. Business Associate shall retain no copies of the PHI.
- b. If Business Associate determines that returning the PHI is infeasible, Business Associate shall notify Covered Entity of the conditions that make return infeasible. Upon mutual agreement of the parties that return of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return infeasible, for so long as Business Associate maintains such PHI.

G. Security Compliance

Business Associate agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Covered Entity, and will require that its agents and contractors to whom it provides such information do the same. Further, Business Associate agrees to comply with Covered Entity's security policies and procedures. Business Associate also agrees to provide Covered Entity with access to and information concerning Business Associate's security and confidentiality policies, processes, and practices that affect electronic PHI provided to or created by Business Associate pursuant to the Agreement upon reasonable request of the Covered Entity. Covered Entity shall determine if Business Associate's security and confidentiality practices, policies, and processes comply with HIPAA and all regulations promulgated under HIPAA. Additionally, Business Associate will immediately report to Covered Entity any Security Incident of which it becomes aware.

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H. Miscellaneous

1. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.
2. The Parties agree to amend this Agreement as necessary to comply with HIPAA and other applicable law.
3. The respective rights and obligations of Business Associate under **§ F.2** shall survive the termination of the Contract.
4. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

DBP Provider Representative

Title: _____

Please print Name: _____

Date: _____

DHH Representative

Title: _____

Please print Name: _____

Date: _____

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Attachment E

Cost and Pricing Template

Only Contract Year One will be Evaluated and Scored

PROPOSER: ADDRESS: CITY, STATE, ZIP CODE:												
Cost Proposal - Dental Benefit Plan Contract Year 1 (March 1, 2013 to January 31, 2014)												
Category of Service	Estimated Member Months	Base period Per Member Per Month	Base Period Utilization per 1,000	Base Period Average Unit Cost	Trend Factor	Adjustment - IBNR Factor	Adjustment - TPL Factor	Adjustment - Utilization Factor	Adjustment - Managed Care Factor	Administrative Load Factor	Premium Assessment Factor	Proposed PMPM for Contract Year 1*
Medicaid under age 21												
Preventative												
Restorative												
Orthodontic												
Proposed Medicaid PMPM												
LA CHIP												
Preventative												
Restorative												
Orthodontic												
Proposed LA CHIP PMPM												
All COA Composite												
Please specify base period used for pricing in column E above - FY 12 or weighted average of FY 11 & FY12.												

*Proposed PMPM must consider premium tax specified in Section 21.20.4 and 23.3.2 of the RFP.

PROPOSER: ADDRESS: CITY, STATE, ZIP CODE:												
Estimated Cost Proposal - Dental Benefit Plan Contract Year 2 (February 1, 2014 to January 31, 2015 (Informational Purposes Only)												
Category of Service	Estimated Member Months	Base period Per Member Per Month	Base Period Utilization per 1,000	Base Period Average Unit Cost	Trend Factor	Adjustment - IBNR Factor	Adjustment - TPL Factor	Adjustment - Utilization Factor	Adjustment - Managed Care Factor	Administrative Load Factor	Premium Assessment Factor	Proposed PMPM for Contract Year 2*
Medicaid under age 21												
Preventative												
Restorative												
Orthodontic												
Proposed Medicaid PMPM												
LA CHIP												
Preventative												
Restorative												
Orthodontic												
Proposed LA CHIP PMPM												
All COA Composite												
Please specify base period used for pricing in column E above - FY 12 or weighted average of FY 11 & FY12.												

*Proposed PMPM must consider premium tax specified in Section 21.20.4 and 23.3.2 of the RFP.

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Attachment E Cost and Pricing Template

PROPOSER:												
ADDRESS:												
CITY, STATE, ZIP CODE:												
Estimated Cost Proposal - Dental Benefit Plan Contract Year 3 (February 1, 2015 - January 31, 2016) (Informational Purposes Only)												
Category of Service	Estimated Member Months	Base period Per Member Per Month	Base Period Utilization per 1,000	Base Period Average Unit Cost	Trend Factor	Adjustment - IBNR Factor	Adjustment - TPL Factor	Adjustment - Utilization Factor	Adjustment - Managed Care Factor	Administrative Load Factor	Premium Assessment Factor	Proposed PMPM for Contract Year 3*
Medicaid under age 21												
Preventative												
Restorative												
Orthodontic												
Proposed Medicaid PMPM												
LA CHIP												
Preventative												
Restorative												
Orthodontic												
Proposed LA CHIP PMPM												
All COA Composite												
Please specify base period used for pricing in column E above - FY 12 or weighted average of FY 11 & FY12.												

*Proposed PMPM must consider premium tax specified in Section 21.20.4 and 23.3.2 of the RFP.

SUMMARY SHEET

PROPOSER:	
ADDRESS:	
CITY, STATE, ZIP CODE:	
	AVERAGE PMPM
CONTRACT YEAR 1 - AVERAGE PMPM	
CONTRACT YEAR 2- AVERAGE PMPM (For Informational Purposes Only)	
CONTRACT YEAR 3 - AVERAGE PMPM (For Informational Purposes Only)	