STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING AND MATERIALS MANAGEMENT (DPMM)
REQUEST FOR BEST AND FINAL OFFER (BAFO)
FOR REQUEST FOR PROPOSAL (RFP)

BAFO REQUEST NO.: 001
RFP NO.: B3Z15077
TITLE: MO HealthNet Managed Care – Central, Eastern, and Western Regions
ISSUE DATE: 02/13/15

REQ NO.: NR 886 DFA15000026
BUYER: Laura Ortmeyer
PHONE NO.: (573) 751-4579
E-MAIL: laura.ortmeyer@oa.mo.gov

BAFO RESPONSE SHOULD BE RETURNED BY: FEBRUARY 20, 2015 AT 12:00 PM CENTRAL TIME

MAILING INSTRUCTIONS: Print or type **RFP Number** and **Return Due Date** on the lower left hand corner of the envelope or package. Sealed BAFOs should be in DPMM office (301 W High Street, Room 630) by the return date and time.

RETURN BAFO RESPONSE TO:

(U.S. Mail)
DPMM
PO BOX 809
JEFFERSON CITY MO 65102-0809

or

(Courier Service)
DPMM
301 WEST HIGH STREET, RM 630
JEFFERSON CITY MO 65101-1517

CONTRACT PERIOD: July 1, 2015 through June 30, 2016

DELIVER SUPPLIES/SERVICES FOB (Free On Board) DESTINATION TO THE FOLLOWING ADDRESS:

Missouri Department of Social Service, MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102-6500

The offeror hereby declares understanding, agreement and certification of compliance to provide the items and/or services, at the prices quoted, in accordance with all terms and conditions, requirements, and specifications of the original RFP as modified by any previously issued RFP amendments and by this and any previously issued BAFO requests. The offeror agrees that the language of the original RFP as modified by any previously issued RFP amendments and by this and any previously issued BAFO requests shall govern in the event of a conflict with his/her proposal. The offeror further agrees that upon receipt of an authorized purchase order from the Division of Purchasing and Materials Management or when a Notice of Award is signed and issued by an authorized official of the State of Missouri, a binding contract shall exist between the offeror and the State of Missouri.

SIGNATURE REQUIRED

DOING BUSINESS AS (DBA) NAME	LEGAL NAME OF ENTITY/INDIVIDUAL FILED WITH IRS FOR THIS TAX ID NO.
MAILING ADDRESS	IRS FORM 1099 MAILING ADDRESS
CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE

CONTACT PERSON		EMAIL ADDRESS
PHONE NUMBER		FAX NUMBER
TAXPAYER ID NUMBER (TIN)	TAXPAYER ID (TIN) TYPE (CHECK ONE) ___ FEIN ___ SSN	VENDOR NUMBER (IF KNOWN)
VENDOR TAX FILING TYPE WITH IRS (CHECK ONE) ___ Corporation ___ Individual ___ State/Local Government ___ Partnership ___ Sole Proprietor ___IRS Tax-Exempt		
AUTHORIZED SIGNATURE		DATE
PRINTED NAME		TITLE

BEST AND FINAL OFFER (BAFO) #001 to RFP B3Z15077

TITLE: MO HealthNet Managed Care – Central, Eastern, and Western Regions

CONTRACT PERIOD: July 1, 2015 through June 30, 2016

RFP B3Z15077 is hereby revised as follows:

1. The following paragraphs in RFP B3Z15077 contain changes:

   2.2.1 h. and sub items 1) and 2)
   2.4.12 b. and c.
   2.6.9
   2.14.10 a. 2)
   2.18.8 c. 2), 4) and 5)
   2.21.4
   2.21.5 c.
   2.26.5 m.
   2.32.7
   3.9.6 y.
   4.4.3

2. Exhibit C is revised.

3. The following document on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates is revised:

   Federally Qualified Health Center, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Family Planning and STD Providers

STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING AND MATERIALS MANAGEMENT (DPMM)
REQUEST FOR PROPOSAL (RFP)

AMENDMENT NO.: 1
RFP NO.: B3Z15077
TITLE: MO HealthNet Managed Care – Central, Eastern, and Western Regions
ISSUE DATE: 11/26/14

REQ NO.: NR 886 DFA15000026
BUYER: Laura Ortmeyer
PHONE NO.: (573) 751-4579
E-MAIL: laura.ortmeyer@oa.mo.gov

RETURN PROPOSAL NO LATER THAN: DECEMBER 19, 2014 AT 2:00 PM CENTRAL TIME

MAILING INSTRUCTIONS: Print or type **RFP Number** and **Return Due Date** on the lower left hand corner of the envelope or package. Delivered sealed proposals must be in DPMM office (301 W High Street, Room 630) by the return date and time.

RETURN PROPOSAL AND AMENDMENT(S) TO:

(U.S. Mail)		(Courier Service)
DPMM	**or**	**DPMM**
PO BOX 809		**301 WEST HIGH STREET, ROOM 630**
JEFFERSON CITY MO 65102-0809		**JEFFERSON CITY MO 65101-1517**

CONTRACT PERIOD: July 1, 2015 through June 30, 2016

DELIVER SUPPLIES/SERVICES FOB (Free On Board) DESTINATION TO THE FOLLOWING ADDRESS:

Missouri Department of Social Service, MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102-6500

The offeror hereby declares understanding, agreement and certification of compliance to provide the items and/or services, at the prices quoted, in accordance with all terms and conditions, requirements, and specifications of the original RFP as modified by this and any previously issued RFP amendments. The offeror should, as a matter of clarity and assurance, also sign and return all previously issued RFP amendment(s) and the original RFP document. The offeror agrees that the language of the original RFP as modified by this and any previously issued RFP amendments shall govern in the event of a conflict with his/her proposal. The offeror further agrees that upon receipt of an authorized purchase order from the Division of Purchasing and Materials Management or when a Notice of Award is signed and issued by an authorized official of the State of Missouri, a binding contract shall exist between the offeror and the State of Missouri.

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VENDOR TAX FILING TYPE WITH IRS (CHECK ONE) ___ Corporation ___ Individual ___ State/Local Government ___ Partnership ___ Sole Proprietor ___IRS Tax-Exempt		
AUTHORIZED SIGNATURE		DATE
PRINTED NAME		TITLE

AMENDMENT #1 to RFP B3Z15077

TITLE: MO HealthNet Managed Care – Central, Eastern, and Western Regions

CONTRACT PERIOD: July 1, 2015 through June 30, 2016

RFP B3Z15077 is hereby revised as follows:

1. The following paragraphs in RFP B3Z15077 contain changes:

2.1.5 d. and 2.1.5 d. 1) and 2)
2.1.7 b. 3)
2.2.7 b. 1)
2.4.4 c.
2.4.9
2.4.11
2.5.5 e. 6), third bullet point
2.5.6 b. 1) and 4)
2.6.9
2.6.17
2.11.1
2.12.4 g.
2.14.6 d. 2)
2.22.7 b.
2.23.1 a. and b.
2.23.2 b. and c. (formerly 2.23.2 a. and b.)
2.29.3 c. 4), item 1. of the table
2.29.3 d.
4.7.3
4.9.3 b. and d.
2.1.7 a. 4), including the three bullet points
2.2.1 h.
2.4.2 a. 5)
2.4.8 a.
2.4.10
2.4.12 a. 5) and 6)
2.5.6 a. 2), first bullet point
2.6.8 d.
2.6.16 a. and b.
2.7.5 e.
2.11.1 c. 1)
2.13.2 d.
2.14.8 b. 2) thru 4)
2.22.13 a. and 2.22.13.a. 1) thru 4)
2.23.2 a.
2.23.2 c. 3), first bullet point
2.29.3 c. 5), item 1. of the table
4.5
4.7.4

2. Exhibits A, B, C, and H are revised.

3. Attachments 1 and 2 are revised. Additionally, Appendix A and B of Attachment 2 are also provided in an Excel format.

4. Revisions have been made on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates) to the following documents:

   - *Ownership or Controlling Interest Disclosure.*
   - *Health Plan Encounter Data Questionnaire*
   - *Federally Qualified Health Clinics, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Family Planning and STD Providers*

5. Revisions have been made on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/) to the following document:

   - *EPSDT Screening Codes and Methodology*
   - *Mercer Presentation: MO HealthNet Managed Care Rate Development, July 1, 2015-June 30, 2016*

STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING AND MATERIALS MANAGEMENT (DPMM)
REQUEST FOR PROPOSAL (RFP)

RFP NO.: B3Z15077
TITLE: MO HealthNet Managed Care – Central, Eastern, and Western Regions
ISSUE DATE: 10/31/14

REQ NO.: NR 886 DFA15000026
BUYER: Laura Ortmeyer
PHONE NO.: (573) 751-4579
E-MAIL: laura.ortmeyer@oa.mo.gov

RETURN PROPOSAL NO LATER THAN: DECEMBER 19, 2014 AT 2:00 PM CENTRAL TIME

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CONTRACT PERIOD: July 1, 2015 through June 30, 2016

DELIVER SUPPLIES/SERVICES FOB (Free On Board) DESTINATION TO THE FOLLOWING ADDRESS:

Missouri Department of Social Service, MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102-6500

The offeror hereby declares understanding, agreement and certification of compliance to provide the items and/or services, at the prices quoted, in accordance with all requirements and specifications contained herein and the Terms and Conditions Request for Proposal (Revised 12/27/12). The offeror further agrees that the language of this RFP shall govern in the event of a conflict with his/her proposal. The offeror further agrees that upon receipt of an authorized purchase order from the Division of Purchasing and Materials Management or when a Notice of Award is signed and issued by an authorized official of the State of Missouri, a binding contract shall exist between the offeror and the State of Missouri.

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1. INTRODUCTION AND GENERAL INFORMATION

1.1 Introduction:

1.1.1 This document constitutes a request for competitive, sealed proposals for providers of the Missouri Managed Care Program, hereinafter referred to as "MO HealthNet Managed Care". All proposals shall cover the entire MO HealthNet Managed Care area encompassing the following regions of the State of Missouri. Where specifically noted herein, certain provisions, including but not limited to, the capitated rate structure and the enrollment process, will be implemented on a regional basis.

a. Central Region: Audrain, Benton, Boone, Callaway, Camden, Chariton, Cole, Cooper, Gasconade, Howard, Laclede, Linn, Macon, Maries, Marion, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Phelps, Pulaski, Ralls, Randolph, Saline, and Shelby counties.

b. Eastern Region: Franklin, Jefferson, Lincoln, Madison, Perry, Pike, St. Charles, St. Francois, Ste. Genevieve, St. Louis, Warren, and Washington counties, and St. Louis City.

c. Western Region: Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Polk, Ray, St. Clair, and Vernon counties.

1.1.2 Organization - This document, referred to as a Request for Proposal (RFP), is divided into the following parts:

1) Introduction and General Information
2) Scope of Work
3) General Contractual Requirements
4) Proposal Submission Information
5) Pricing Pages - The Pricing Pages are a separate link that must be downloaded from the Division of Purchasing and Materials Management's Internet web site at: https://www.moolb.mo.gov. It shall be the sole responsibility of the offeror to obtain the Pricing Pages.
6) Exhibits A - H : Exhibit C is a separate links that must be downloaded from the Division of Purchasing and Materials Management's Internet web site at: https://www.moolb.mo.gov. It shall be the sole responsibility of the offeror to obtain Exhibit C.
7) Terms and Conditions
8) Attachments 1 and 2: The offeror is advised that attachments exist to this document which provide additional information and instruction. These attachments are separate links that must be downloaded from the Division of Purchasing and Materials Management's Internet web site at: https://www.moolb.mo.gov. It shall be the sole responsibility of the offeror to obtain each of the attachments. The offeror shall not be relieved of any responsibility for performance under the contract due to the failure of the offeror to obtain a copy of the attachments.

1.2 Pre-Proposal Conference - A pre-proposal conference regarding this Request for Proposal will be held at 10:00 a.m. Central Time on Monday, November 10, 2014, in Room 490/492 of the Harry S Truman Building, 301 West High Street, Jefferson City, Missouri.

1.2.1 Pre-Proposal Conference Agenda - The offeror should bring a copy of the RFP since it will be used as the agenda for the pre-proposal conference.

1.2.2 Pre-Proposal Conference RFP Questions – All potential offerors are encouraged to attend the Pre-Proposal Conference as it will be used as the forum for questions, communications, and discussions regarding the RFP. The offeror should become familiar with the RFP and develop all questions prior to the conference in order to ask questions and otherwise participate in the public communications regarding the RFP.

a. Prior Communication – Prior to the Pre-Proposal Conference, the offeror may submit written communications and/or questions regarding the RFP to the buyer identified on page one. Such prior communication will provide the State of Missouri with insight into areas of the RFP which may be brought up for discussion during the conference and which may require clarification.

b. During the Pre-Proposal Conference, it shall be the sole responsibility of the offeror to orally address all issues previously presented to the buyer by the offeror, including any questions regarding the RFP or areas of the RFP requiring clarification.

c. Amendment to the RFP - Any changes needed to the RFP as a result of discussions from the Pre-Proposal Conference will be accomplished as an amendment to the RFP. Neither formal minutes of the conference nor written records of the questions/communications will be maintained.

1.2.3 Pre-Proposal Conference Special Accommodations - Offerors are strongly encouraged to advise the Division of Purchasing and Materials Management within five (5) working days of the scheduled pre-proposal conference of any special accommodations needed for disabled personnel who will be attending the conference so that these accommodations can be made.

1.3 Available Documentation:

1.3.1 The offeror is advised that important documents, instructions, schedules, and templates exist in addition to this document. This information is located on the MO HealthNet Division website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/) and Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

1.3.2 All possible efforts have been made to ensure that the information provided in these relevant documents is complete and current. However, the offeror shall not assume that such information is indeed complete or current.

1.4 Description of MO HealthNet Managed Care Program:

1.4.1 Effective July 1, 2015, the State of Missouri will continue a statewide health care delivery program in the Central, Eastern, and Western Regions of the State. The goals are to improve access to needed services and the quality of health care services for the MO HealthNet Managed Care and State aid eligible populations, while controlling the program's rate of cost increase.

a. The Missouri Department of Social Services, MO HealthNet Division intends to achieve this goal by enrolling MO HealthNet Managed Care eligibles in comprehensive, qualified health plans that contract with the State of Missouri to provide a specified scope of benefits to each enrolled member in return for a capitated payment made on a per member, per month basis.

b. An open enrollment period will be conducted prior to full implementation of all contracts that result from this Request for Proposal.

1.4.2 The health care delivery program was designed through a collaborative process that included feedback from providers, consumers, health plans, communities, the State of Missouri government agencies, and the Centers for Medicare & Medicaid Services (CMS).

1.4.3 The Missouri Department of Social Services, MO HealthNet Division has identified nine (9) guiding principles for the MO HealthNet Program as follows:

a. All members must be linked with a primary care provider, as defined herein, of their choice.

b. Attention to wellness of the individual (e.g. education) and prevention of disease.

c. Chronic care management.

d. Case management – (resources focused towards people receiving the services they need, not necessarily because the service is available).

e. Utilization of the appropriate setting at the right cost.

f. Emphasis on the individual person.

g. Evidenced based guidelines for improved quality of care and use of resources.

h. Encourage responsibility and investment on the part of the member to ensure wellness.

i. Participation in the Medicaid Reform and Transformation Program, which includes personal responsibility (member incentives), the Local Community Care Coordination Program (LCCCP) initiative, state provider incentive program, and requirements for increased accountability and transparency.

1.5 Program Management and Oversight:

1.5.1 In the State of Missouri, the Department of Social Services, MO HealthNet Division is officially designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) programs. The Family Support Division (FSD) is designated with the administration and determination of eligibility for the two programs. In addition to MO HealthNet Division's oversight, CMS also monitors MO HealthNet Managed Care activities through its Regional Office in Kansas City, Missouri and its Center for Medicaid, CHIP and Survey & Certification, Division of Integrated Health Systems in Baltimore, Maryland.

1.5.2 During the term of the contract, and in future years, the Missouri Department of Social Services, MO HealthNet Division will modify its Medicaid and CHIP programs, including the MO HealthNet Managed Care Program, in order to conform with the Federal requirements of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148), enacted March 23, 2010; and the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152), enacted March 30, 2010. (Collectively, these two pieces of legislation will be referred to hereinafter as the ACA.)

1.6 MO HealthNet Managed Care Program Eligibility Groups:

1.6.1 For purposes of this RFP, the MO HealthNet Managed Care population consists of different eligibility groups which have been combined for the purpose of rate setting. The qualifications for the program are based on a combination of factors, including family composition, income level, insurance status, or pregnancy status depending on the eligibility group in question. The eligibility groups and their current estimated sizes are described below and summarized in Attachment 1, *MO HealthNet Managed Care and Related Eligibility Groups*, and located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/).

a. Eligibility of Parents/Caretakers, Children, and Refugees: Individuals covered under MO HealthNet Managed Care within this group are as follows:

1) Parents/Caretakers and Children eligible under MO HealthNet for Families, and Transitional MO HealthNet Assistance;

2) Children eligible under MO HealthNet for Poverty Level Children;

3) Individuals eligible under Participants of Refugee MO HealthNet;

4) Individuals who are eligible under the above groups and are participants in the following Developmental Disabilities (DD) waivers: Partnership for Hope, DD Comprehensive, DD Community Support, and Autism; and

5) Those who are eligible are defined by their MO HealthNet Medical Eligibility (ME) Codes as specified in Attachment 1, *MO HealthNet Managed Care and Related Eligibility Groups*, and located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/).

b. Eligibility of Pregnant Women: Individuals covered under MO HealthNet Managed Care within this group are women eligible under MO HealthNet for Pregnant Women and 60 days post-partum.

Those who are eligible are defined by their MO HealthNet Medical Eligibility (ME) Codes as specified in Attachment 1, *MO HealthNet Managed Care and Related Eligibility Groups*, and located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents).

c. Eligibility of Other MO HealthNet Children In the Care and Custody of the State and Receiving Adoption Subsidy Assistance: All children in the care and custody of the Department of Social Services; all children placed in a not-for-profit residential group home by a juvenile court; all children receiving adoption subsidy assistance; and all children receiving non-medical assistance (i.e., living expenses) that are in the legal custody of the Department of Social Services shall remain the responsibility of the Department of Social Services. Those that are eligible are defined by their MO HealthNet Medical Eligibility Code as specified in Attachment 1, *MO HealthNet Managed Care and Related Eligibility Groups*, and located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/).

Persons under twenty-six years of age, who were in foster care on their eighteenth birthday and covered by MO HealthNet, and who meet other eligibility criteria, are eligible under this category of assistance.

d. State Child Health Plan: Missouri has an approved combination State Child Health Plan under Title XXI of the Social Security Act (the Act) for the Children's Health Insurance Program (CHIP). Missouri's CHIP State Child Health Plan uses funds provided under Title XXI to both expand eligibility under Missouri's State Medicaid Plan, and to obtain coverage that meets the requirements for a separate child health program. Those that are eligible are defined by their MO HealthNet Medical Eligibility Code as specified in the Attachment 1, *MO HealthNet Managed Care and Related Eligibility Groups*, and located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/)

e. MO HealthNet Managed Care eligibles in the above specified eligibility groups may voluntarily disenroll from the Managed Care Program or choose not to enroll in the Managed Care Program if they:

1) Are eligible for Supplemental Security Income (SSI) under Title XVI of the Act;

2) Are described in Section 501(a)(1)(D) of the Act;

3) Are described in Section 1902 (e)(3) of the Act;

4) Are receiving foster care or adoption assistance under part E of Title IV of the Act;

5) Are in foster care or otherwise in out-of-home placement; or

6) Meet the SSI disability definition as determined by the Department of Social Services.

1.6.2 **Not Covered Under the MO HealthNet Managed Care Program**: The following individuals are not covered under the MO HealthNet Managed Care Program and receive their services through the MO HealthNet Fee-For-Service Program:

a. Permanently and Totally Disabled and Aged individuals eligible under ME Codes 04 (Permanently and Totally Disabled), 13 (MO HealthNet-PTD), 16 (Nursing Care-PTD), 11 (MO HealthNet Spenddown and Non-Spenddown), 14 (Nursing Care–OAA), and 01 (Old Age Assistance-OAA);

b. Individuals eligible under ME Codes 23 and 41 (MA ICF-MR Poverty) residing in a State Mental Institution or an Intermediate Care Facility for the Intellectually Disabled (ICF/ID);

c. Individuals eligible under ME Codes 28, 49, and 67 (Children placed in foster homes or residential care by the Department of Mental Health);

d. Pregnant women eligible under ME Code 58 and 59, the Presumptive Eligibility Program for ambulatory prenatal care only;

e. Individuals eligible under ME Codes 2, 3, 12, and 15 (Aid to the Blind and Blind Pension);

f. AIDS Waiver participants (individuals twenty-one (21) years of age and over);

g. Any individual eligible and receiving either or both Medicare Part A and Part B or Part C benefits;

h. Individuals eligible under ME Codes 33 and 34 (MO Children with Developmental Disabilities Waiver);

i. Individuals eligible under ME Code 55 (Qualified Medicare Beneficiary – QMB);

j. Children eligible under ME Code 65, placed in residential care by their parents, if eligible for MO HealthNet on the date of placement;

k. Uninsured women losing their MO HealthNet eligibility 60 days after the birth of their child would be eligible under ME Code 80 for women's health services for one year plus 60 days, regardless of income level;

l. Women eligible for Women's Health Services, 1115 Waiver Demonstration, ME code 89. These are uninsured women who are at least 18 to 55 years of age, with a net family income at or below 185% of the Federal Poverty Level (FPL), and with assets totaling less than $250,000. These women are eligible for women's health services as long as they continue to meet eligibility requirements;

m. Individuals with ME code 81 (Temporary Assignment Category);

n. Individuals eligible under ME code 82 (MoRx);

o. Women eligible under ME codes 83 and 84 (Breast and Cervical Cancer Treatment);

p. Individuals eligible under ME code 87 (Presumptive Eligibility for Children); and

q. Individuals eligible under ME code 88 (Voluntary Placement).

1.6.3 Where economically cost effective, the MO HealthNet Division will use the MO HealthNet Division's Health Insurance Premium Payment (HIPP) program to obtain available coverage through available commercial insurance. Those services included in the comprehensive benefit packages described herein, but not included in the commercial insurance service package, may be obtained through MO HealthNet Managed Care or Fee-For-Service as appropriate.

1.7 Information:

1.7.1 A listing of MO HealthNet acronyms is available under *MO HealthNet Acronyms* located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/).

1.7.2 Although an attempt has been made to provide accurate and up-to-date information, the State of Missouri does not warrant or represent that the information provided within this section reflects all relationships or existing conditions related to this Request for Proposal.

1.7.3 The State of Missouri has previously contracted for the services being obtained via this RFP. A copy of the contracts can be viewed and printed from the Division of Purchasing and Materials Management's Awarded Bid & Contract Document Search System located on the Internet at: http://content.oa.mo.gov/purchasing-materials-management/. In addition, all proposal and evaluation documentation leading to the award of the contracts may also be viewed and printed from the Division of Purchasing and Materials Management's Awarded Bid & Contract Document Search System. Please reference the bid number B3Z12055 or contract numbers C312055001, C312055002, and C312055003 when searching for these documents.

2. SCOPE OF WORK

2.1 General Requirements:

2.1.1 The contractor (hereinafter referred to as the "health plan") shall provide a managed care medical service delivery system for the Department of Social Services, MO HealthNet Division (hereinafter referred to as the "state agency"), located in the State of Missouri in accordance with the provisions and requirements stated herein.

2.1.2 The health plan shall adhere to all applicable local, State and Federal requirements regarding operation of the MO HealthNet Managed Care Program.

2.1.3 The health plan shall cooperate with the state agency, as directed, in the implementation of the requirements of the Patient Protection and Affordable Care Act (ACA). Any ACA requirements altering the obligations of the health plan under the contract shall be accomplished through contract provisions, which may differ from the terms of the contract, to the extent that relevant Federal guidance is issued after the effective date of the contract; or through a contract amendment, as required herein, to the extent that relevant Federal guidance is issued during the term of the contract. The state agency may implement ACA requirements that impact the health plan's operations, but do not directly alter its contractual obligations, through the issuance of a provider bulletin.

2.1.4 Prior to performing services in each of the counties, the health plan shall:

a. Have and maintain a certificate of authority from the Department of Insurance, Financial Institutions & Professional Registration to establish and operate a health maintenance organization (HMO) in all the counties specified herein by no later than April 3, 2015 so that the state agency can proceed with open enrollment with only health plans that are appropriately licensed. In the event the health plan is awarded a contract and fails to achieve appropriate licensure by April 3, 2015, the contract shall be cancelled in its entirety.

b. Understand that Federal approval of the contract is required prior to commitment of the Federal financing share of funds under the contract.

c. Participate in readiness reviews. If the health plan is new to the MO HealthNet Managed Care Program, the state agency shall conduct an on-site readiness review of the health plan in order to document the status of the health plan with respect to meeting the requirements outlined herein. If the health plan has an established relationship with the state agency, the state agency may either (1) conduct an off-site readiness review of the health plan in order to document the status of the health plan with respect to meeting any new contractual requirements from previous contracts, or (2) conduct an on-site readiness review at the state agency's discretion. The implementation plan, as submitted in the health plan's awarded proposal, and adherence to the implementation plan shall be monitored by the state agency as part of readiness review activities.

   A readiness review of the health plan's case management and disease management program will be conducted for all health plans regardless of whether they have an established relationship with the state agency. This readiness review may be conducted on-site at the state agency's discretion. The health plan shall submit all necessary documentation and complete a self-reporting tool to be submitted to the state agency. The health plan is subject to a desk audit validation of the submitted documentation. In addition to the readiness review, the health plan's case management and disease management programs will be reviewed on an annual basis using the same tool. The tool is subject to review and modifications by the state agency at the state agency's discretion.

d. Submit to the state agency all policies and procedures that require prior approval as requested by the state agency. The required policies and procedures may be accessed at: *Policies and Procedures Requiring Prior Approval* located on the MO HealthNet website at Health Plan Reporting Schedule

and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/). The health plan shall access the *Policy Submission Form* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/) to submit all modifications, additions, or deletions to such policies and procedures to the state agency at least thirty (30) days prior to implementation. The health plan shall operate in accordance with such policies and procedures. The health plan shall incorporate and implement any revisions identified by the state agency to the health plan's policies and procedures within the timeframe specified by the state agency. All other policies and procedures required herein shall be submitted to the state agency on request.

2.1.5 The health plan awarded a contract for the MO HealthNet Managed Care Program shall provide services to individuals determined eligible by the state agency for the MO HealthNet Managed Care Program in all of the following fifty-four (54) counties in the three (3) designated regions of the State of Missouri:

a. Eastern Region:
   1) Franklin County
   2) Jefferson County
   3) Lincoln County
   4) Madison County
   5) Perry County
   6) Pike County
   7) St. Charles County
   8) St. Francois County
   9) Ste. Genevieve County
   10) St. Louis County
   11) Warren County
   12) Washington County
   13) St. Louis City

b. Central Region:
   1) Audrain County
   2) Benton County
   3) Boone County
   4) Callaway County
   5) Camden County
   6) Chariton County
   7) Cole County
   8) Cooper County
   9) Gasconade County
   10) Howard County
   11) Laclede County
   12) Linn County
   13) Macon County
   14) Maries County
   15) Marion County
   16) Miller County
   17) Moniteau County
   18) Monroe County
   19) Montgomery County
   20) Morgan County
   21) Osage County
   22) Pettis County
   23) Phelps County
   24) Pulaski County

25) Ralls County
26) Randolph County
27) Saline County
28) Shelby County

c. Western Region:
1) Bates County
2) Cass County
3) Cedar County
4) Clay County
5) Henry County
6) Jackson County
7) Johnson County
8) Lafayette County
9) Platte County
10) Polk County
11) Ray County
12) St. Clair County
13) Vernon County

AMENDMENT 1 ADDED THE FOLLOWING PARAGRAPH:

d. The state agency will notify the health plan if:

AMENDMENT 1 ADDED THE FOLLOWING PARAGRAPH:

1) There are any significant changes in services, benefits, geographic service areas, or payments; or

AMENDMENT 1 ADDED THE FOLLOWING PARAGRAPH:

2) The state agency requires enrollment of a new population in the health plan.

2.1.6 The state agency implemented a health home program designated by Section 2703 of the ACA for eligible MO HealthNet members.

a. The health plan must provide coordination with a primary care provider for members participating in the state agency's health home program.

b. On a monthly basis, the state agency will notify the health plan which of its members are receiving health home services and a contact person will be provided for each health home to allow for coordination of a member's services.

c. The health plan must identify a single point of contact for the Section 2703 designated health home practice.

d. The health plan is not required to provide case management services that duplicate those reimbursed to the Section 2703 designated health home.

e. The health plan must inform the health home of any inpatient admission or discharge of a health home member within twenty-four hours.

f. The health plan should include any Section 2703 designated health home treating physician, clinical practice, or advance practice nurse in their provider network for members in a Section 2703 designated health home.

2.1.7 Medicaid Reform and Transformation:

The health plan shall provide programs involving: personal responsibility, promoting efficiency through state provider incentives, and the Local Community Care Coordination Program designed to engage members, providers, and health plans in transforming the state agency's service delivery system, and increasing accountability and transparency.

a. Personal Responsibility: The health plan shall offer member incentives to members in order to promote responsible behavior and encourage efficient use of health care services.

1) The health plan shall establish a member incentive program with the following activities in mind:

- To promote healthy behaviors and encourage members to take ownership of their health care by seeking early preventive care in appropriate settings;
- To promote the adoption of healthier personal habits including but not limited to tobacco use, behaviors that lead to obesity, control of asthma, control of diabetes, etc.;
- To promote enhanced engagement and greater health literacy among members; and
- To promote appropriate use of emergency room services.

2) The health plan's member incentives:

- Must be directly related to a health plan quality initiative;
- Must be measurable;
- Cannot be used in conjunction with the health plan's marketing activities; and
- Cannot be convertible to cash or be eligible for redemption in any way for alcohol, tobacco products, firearms, or ammunition.

3) The contractor shall agree and understand that the member incentive program submitted in the contractor's awarded proposal shall be subject to the state agency's final review and approval. Contract award does not constitute approval or acceptance of the member incentive program proposed in the health plan's awarded proposal. Member incentive programs from prior contracts will not be exempted from approval. The state agency's approval process includes an evaluation of the health plan's member incentive program using a format provided by the state agency. Please see *Focused Study of Health Care* located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/).

- The outreach or education related to the proposed member incentives must be approved by the state agency through the established marketing process. Any activities that are passive in nature and not explicitly aimed at promoting greater member engagement will not be approved. Marketing activities shall not be utilized in a way that could construe them as incentives to join a particular health plan.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

4) The health plan shall document its efforts to inform all members about the opportunity to participate in the member incentive program. The health plan shall ensure that at a minimum:

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

- Ten percent (10%) of non-duplicative members in the first year of the contract participate in the member incentive program;

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

- Twenty percent (20%) of non-duplicative members in the second year of the contract participate in the member incentive program; and

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

- Thirty percent (30%) of non-duplicative members in the third year of the contract participate in the member incentive program.

5) Member incentive gifts related to the delivery of preventive care services as defined by the US Preventive Services Taskforce are limited to a value of $30.00 or less per eligible member per month, per incentive program.

6) Member incentive gifts not related to preventive care services defined by the US Preventive Services Taskforce are limited to a value of $10.00 each or an aggregate annual value of $50.00.

7) The health plan shall monitor their member incentive program to ensure that the program has met the health plan's quality initiative and to evaluate on an ongoing basis the effectiveness of the member incentive program based on the program submitted to and approved by the state agency. Monitoring activities may include, but are not limited to, audits and secret shopper activities conducted by the state agency.

8) The health plan shall report the status and results of member incentive programs to the state agency as requested.

b. State Provider Incentive Program:

1) The health plan shall use the state provider incentive program with providers and provider groups to promote and achieve the following goals:
   - Improve members' health outcomes;
   - Decrease inappropriate utilization of services;
   - Decrease health risk factors in the populations the providers and provider groups serve.

2) The health plan shall require that all subcontractors, including any health care services subcontractors, comply with all provider incentive requirements outlined herein.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

3) The contractor shall agree that the state provider incentive program submitted in the contractor's awarded proposal shall be subject to the state agency's final review and approval. Contract award does not constitute approval or acceptance of the state provider incentive program proposed in the health plan's awarded proposal. The health plan shall submit a plan for the health plan's state provider incentive program to the state agency for approval prior to implementation. The plan must ensure that the health plan achieves ten percent (10%) growth in each of the health plan's state provider incentive programs, each year of the contract. However, if the health plan achieves fifty percent (50%) participation in the health plan's state provider incentive programs, the health plan will be considered to have met this requirement.

4) The health plan's state provider incentive program shall include, at a minimum, the following information:

   - Whether services furnished by the rendering provider or provider group are covered by the state provider incentive program. No further disclosure shall be required if the state

provider incentive program does not cover services furnished by the rendering provider or the provider groups in question;

- Effective date of the state provider incentive program;
- The type of state provider incentive program;
- The percent of withhold or bonus applied, if applicable;
- If the rendering provider or provider group is at substantial financial risk, proof that the rendering provider or provider group has adequate stop loss coverage;
- The amount and type of stop-loss protection, if applicable;
- The patient panel size;
- If the patient panel is pooled, a description of the approved method;
- The computations of significant financial risk; and
- Name, address, phone number, and other contact information for a person from the health plan who may be contacted with questions regarding the incentive arrangement.

5) Once the state agency has approved the submitted state provider incentive program plan, the state agency will regularly monitor the health plan's activities based on the approved plan. Monitoring activities may include, but are not limited to, audits and secret shopper activities which may be conducted by the state agency.

6) Annually, the health plan shall submit a disclosure statement to the state agency indicating whether or not there have been changes to the health plan's state provider incentive program plan. If no changes were made to the state provider incentive program plan, the health plan shall submit a statement certifying that no changes were made.

7) The health plan shall maintain all state provider incentive program plan reporting and disclosures in the health plan's files for review by the state agency upon request.

8) The health plan shall notify the state agency within five (5) business days of any change to the health plan's or the subcontractors' state provider incentive program plan.

9) The health plan shall ensure that no financial or non-financial incentives offered directly or indirectly to a provider or provider group induce the provider or provider group in any way to limit or reduce medically necessary services furnished to any member.

10) Federal Physician Incentive Plan Requirements:

- The health plan may establish physician incentive plans pursuant to Federal and State regulations, including 42 CFR § 422.208, 422.210 and 438.6. The health plan shall require all subcontractors, including any health care services subcontractors, comply with all physician incentive plan regulations. The physician incentive plan regulations do not apply outside the scope of incentive plans for healthcare providers providing services to Medicare or MO HealthNet managed care members.

- The health plan shall not offer financial incentives to induce physicians to limit or reduce medically necessary services to a specific member. The health plan shall not offer non-financial incentives to limit or reduce medically necessary services to a specific member.

- A physician group is at "substantial" financial risk if more than twenty-five percent (25%) of its potential payment is at risk for services it does not provide.

  - If a physician group is at “substantial” financial risk, the health plan shall provide adequate protection to limit financial losses. The health plan has the option of: (1) retaining the risk in its direct provider contracts, or (2) the Managed Care Organization (MCO), intermediate entity, physician, or physician group can reinsure the risk through a reinsurance carrier. Stop-loss protection must cover at least ninety percent (90%) of the costs of referral amounts that exceed twenty-five percent (25%) of the total potential payment on either a per member, per year or an aggregate basis.

  - For the purposes of the physician incentive plan regulation, the term “physician” is defined as: Doctors of medicine, doctors of osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, chiropractors, and any limited practice provider that provides services on state agency authority to perform such services.

- If the health plan chooses to establish a physician incentive plan, the health plan shall submit the physician incentive plan to the state agency for approval prior to implementation. The information to be disclosed shall include the following:

  - Effective date of the physician incentive plan;

  - The type of incentive arrangement;

  - The amount and type of stop-loss protection;

  - The patient panel size;

  - If the patient panel is pooled, a description of the method;

  - The computations of significant financial risk; and

  - Name, address, phone number, and other contact information for a person from the health plan who may be contacted with questions regarding the physician incentive plan.

- Annually, the health plan shall submit a disclosure statement to the state agency indicating whether or not there have been changes to the health plan’s physician incentive plan arrangements. If no changes were made to the physician incentive plan arrangements, the health plan shall submit a statement certifying that no changes were made.

- The health plan shall maintain all physician incentive plan reporting and disclosures in their files for review by the state agency upon request.

- In compliance with the Federal regulation, the health plan shall disclose to the members, upon request, whether the health plan uses a physician incentive plan, what type of physician incentive plan the health plan uses, and whether stop-loss insurance is provided.

- The health plan shall notify the state agency within five (5) business days of any change to the health plan or the subcontractors’ physician incentive plans.

c. Local Community Care Coordination Program (LCCCP)

1) The health plan shall develop a Local Community Care Coordination Program (LCCCP) to be implemented no later than July 1, 2016. Such program may use any delivery model that focuses on providing case management, care coordination, and disease management through local healthcare providers; however such model shall be prior approved by the state agency. Models may include accountable care organizations (ACOs), patient-centered medical homes (PCMHs), primary care case management (PCCM), a combination thereof, or other similar models consistent with the principles and requirements listed below. Providers within these applicable models may include, but are not limited to, primary care physicians/specialties/groups, CMHCs, FQHCs, behavioral health providers/groups, or other provider types or groups that coordinate and manage the care of members. The health plan shall submit to the state agency for prior review and written approval the health plan's LCCCP application and program model by December 31, 2015. The health plan shall also describe its own internal case management program to which members not enrolled, eligible, or opting into one of the other models would default. The state agency will work with the health plan to achieve an appropriate and approvable LCCCP model from January 1, 2016 through March 30, 2016. Once the health plan receives written approval on its application from the state agency, the health plan should implement the LCCCP as soon as feasible but no later than July 1, 2016. The health plan's failure to timely submit a LCCCP application to the state agency and/or failure to obtain approval from the state agency on its LCCCP application and program model may result in the withheld funds (described elsewhere herein) not being returned in their entirety to the health plan.

2) Individuals enrolled in the state-operated health homes shall not be included in a LCCCP. Individuals enrolled in either a state-operated health home or state-approved LCCCP are not required to be included in the general case management requirements stipulated herein.

3) The health plan's LCCCP application shall explain how the program will operate to ensure that services are coordinated and not duplicative of any other services provided by the health plan. In addition, the LCCCP application shall explain how members may transition between such programs (as medically necessary and appropriate).

4) The health plan's LCCCP is encouraged to achieve some form of national recognition and/or certification.

5) All LCCCPs shall incorporate the following principles:

- Every member has a selected primary care provider;
- Care is provided by a physician-directed team that collectively cares for the member;
- Care is coordinated and/or integrated across all aspects of health care;
- Case management (e.g. care coordination, finding gaps in care, disease management, and face to face interactions when necessary) is performed at the local level by the LCCCP;
- Care includes recognition of and referral to necessary community and social support options; and
- In the LCCCP, the health plan may utilize licensed professional social workers to provide behavioral health services without restriction as to age of the Managed Care member.

6) The health plan shall ensure that each LCCCP:

- Provides patient-centered care;
- Practices evidence-based medicine and clinical decision supports;
- Participates in continuous quality improvement and performance measurement;
- Coordinates care between all the healthcare providers utilized by the member;
- Engages members and/or family members to actively participate in decision-making and provide feedback;
- Uses health information technology to support care delivery and efficiency improvement;
- Provides for enhanced access, including but not limited to, extended office hours outside of 8:00 AM to 5:00 PM (Central Time), open scheduling, and alternative communication models such as web-based or telephonic options; and
- Members enrolled in a LCCCP are not eligible for the state's health home program and the health plan's case management services.
- It is anticipated that the development and implementation of all LCCCPs shall be budget neutral throughout the contract term.

7) In its LCCCP application, the health plan shall provide its plan for sharing any claims data, case management data, and other data available with the providers within their chosen model to effectively meet the obligations of its LCCCP.

8) The health plan's LCCCP model shall support engagement and transition of primary care practices to LCCCPs by focusing on the following areas:

- Screening/identification and targeting of LCCCP participants including but not limited to:
  - Members with an identified disease state/condition aligned with the health plan's proposed disease management programs; and
  - Members identified with a higher level of need for continuity of care such as those with a behavioral health diagnosis including substance abuse that adversely effects the member's life, those with frequent emergency department visits or hospital admissions and re-admissions, or those with co-morbid health conditions that require a heightened level of attention;
- Continuous, accessible, comprehensive, and coordinated care using community-based resources as appropriate;
- Focusing care on prevention, chronic care management, reducing emergency room visits and unnecessary hospitalizations, and improving care transitions;
- Using access and quality measures (HEDIS and surveys), as defined by the state agency;
- Demonstrating improved health status and outcomes for members as defined by the state agency; and
- Promoting integration between primary care and other providers of covered services through care coordination as well as data exchange; specifically, data that may be used to

support decision making and continuous quality improvement, which may include the release of Medicaid claims/encounter data, health plans claims/encounter data, and health plan authorization data as directed by the state agency.

9) The health plan shall submit to the state agency LCCCP activities and expenditures in the format and frequency specified by the state agency in *Local Community Care Coordination Program Activities and Expenditures Report* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

d. Accountability and Transparency- The health plan shall implement internal controls, policies, and procedures to prevent, coordinate, detect, investigate, enforce, and report fraud, waste, and abuse. The health plan shall also ensure that all employees, subcontractors, providers, and members are properly educated about their individual responsibilities; the responsibilities of others; as well as how fraud, waste, and abuse is defined and how and in what instances to report it. Finally, the health plan shall ensure that the health plan's employees, subcontractors, providers, and members meet all requirements outlined in the Fraud Waste and Abuse, Operational Data Reporting, Encounter Data and Transactions, Member Grievance System, and Provider Complaints and Appeals sections of the contract.

2.2 Health Plan Administration:

2.2.1 The health plan shall have in place sufficient administrative personnel and an organizational structure to comply with all requirements described herein. The health plan shall provide qualified persons in numbers appropriate to the health plan's size of enrollment. At a minimum, the health plan shall have the following personnel to perform the responsibilities listed. Unless otherwise specified, the health plan may combine or split the listed responsibilities among the health plan's personnel as long as the health plan demonstrates that the responsibilities are being met. Similarly, the health plan may contract with a third party (subcontractor) to perform one or more of these responsibilities.

a. A full time Health Plan Administrator with clear authority over the general administration and implementation of the requirements set forth herein.

b. Clerical and support staff to ensure appropriate functioning of the health plan's operation.

c. A Medical Director, for physical and behavioral health, who is a Missouri-licensed physician, has or does practice medicine in the United States, and is in good standing with the State Board of Medical Licensure, has not had his/her license revoked or suspended under 20 CSR 2150.2. The Medical Director shall sign any denial letter required under the Missouri regulation. He/she must be board-certified, board-eligible, or have sufficient experience in his/her field or specialty to be determined competent by the health plan's Credentials Committee. The Medical Director shall be a primary leader of the organization, being actively involved in all clinical and quality program components of the health plan and shall be responsible for the treatment policies, protocols, quality assurance activities, and utilization management decisions of the health plan. The Medical Director shall devote sufficient time to the health plan to ensure timely medical decisions, including after-hours consultation as needed. The Medical Director shall report to the Health Plan Administrator and be responsible for the sufficiency and supervision of the health plan provider network; oversee the development of clinical care standards, practice guidelines, and protocols; and maintain current medical information pertaining to clinical practice and guidelines. The Medical Director must be available to the health plan's medical staff for consultation on referrals, denials, grievances and appeals, and problems. The following health plan staff shall report to the Medical Director: the Quality Assessment and Improvement and Utilization Management Coordinator and the Case Management Supervisor. The Medical Director shall ensure compliance with the National Committee for Quality Assurance (NCQA), and all Federal, State and local reporting laws on communicable diseases, child abuse, neglect, etc.

d. A Dental Consultant who is a Missouri-licensed dentist. The Dental Consultant shall devote sufficient time to the health plan to ensure timely dental decisions and claim review.

e. A full-time Chief Financial Officer to oversee the budget and accounting systems implemented by the health plan.

f. A Quality Assessment and Improvement and Utilization Management Coordinator who is a registered nurse, nurse practitioner, or physician. The registered nurse or nurse practitioner must be licensed in the State of Missouri. The Quality Assessment and Improvement and Utilization Management Coordinator must have formal certification in quality improvement, risk management, or another parallel field. The physician must be Missouri licensed and has practiced or does practice medicine in the United States. He/she must be board-certified, board-eligible, or have sufficient experience in his or her field or specialty to be determined competent by the health plan's Medical Director or the Credentials Committee.

g. A Special Programs Coordinator who is either (1) a Missouri-licensed social worker; (2) a Missouri-licensed registered nurse including advanced practice nurse, physician, or physician's assistant; or (3) has a Master's degree in health services, public health, or health care administration. In addition, the Special Programs Coordinator should be familiar with the variety of services available through the Missouri human services agencies that interface with health care. The duties of the Special Programs Coordinator shall include care coordination with all stakeholders and providers involved in the care of members. These stakeholders and providers may include, but not be limited to, the state agency, the Department of Health and Senior Services (DHSS), local public health agencies, the Department of Mental Health (DMH), the Department of Elementary and Secondary Education (DESE), the Family Support Division (FSD), Children's Division (CD), hospitals, the judicial system, schools, and Community Mental Health Centers (CMHCs). The Special Programs Coordinator shall provide timely and comprehensive facilitation of the identification of medically necessary services and implementation of such when included in a member's Individualized Education Program/Individual Family Service Plan. The Special Programs Coordinator is the main point of contact for members, their representatives, providers, the state agencies, and local public health agencies.

BAFO 001 AND AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH. BAFO 001 ADDED THE SUB ITEMS:

h. Case Management Supervisors. The Case Management Supervisors shall be responsible for all staff and activities related to the case management program, and shall be responsible for ensuring the functioning of case management activities across the continuum of care. The health plan shall provide Case Management Supervisors with the following qualifications, unless otherwise requested and justified by the health plan and approved by the state agency:

1) A Case Management Supervisor for behavioral health services is either a Missouri-licensed Mental Health Clinical Nurse Specialist, Mental Health Nurse Practitioner, or a Missouri licensed psychologist.
2) A Case Management Supervisor for medical services is a Missouri-licensed registered nurse.

i. A Behavioral Health Coordinator, who is licensed in the State of Missouri, is a qualified behavioral health professional (QBHP) as specified herein, and possesses, at a minimum, a master's degree.

j. Prior Authorization Staff that are available to authorize services twenty-four (24) hours per day, seven (7) days per week. Prior Authorization Staff shall be directly supervised by a Missouri-licensed registered nurse, physician, or physician's assistant. Prior authorization functions for behavioral health services shall be performed and/or supervised by a licensed QBHP.

k. Inpatient Certification Review Staff to conduct inpatient initial, concurrent, and retrospective reviews. The Inpatient Certification Review Staff shall consist of Missouri-licensed registered nurses, physicians, physician's assistants, and/or Missouri-licensed practical nurses experienced in inpatient reviews and be under the direct supervision of a Missouri-licensed registered nurse, physician, or physician's assistant. Inpatient Certification Review Staff functions for behavioral health services shall be performed by licensed QBHPs**.**

l. Member Services Staff to coordinate communications with members and act as member advocates. The health plan shall provide sufficient Member Services Staff to enable members to receive prompt resolution to their problems or inquiries.

m. Provider Services Staff to coordinate communications between the health plan and providers. The health plan shall provide sufficient Provider Services Staff to enable providers to receive prompt resolution to their problems or inquiries.

n. A Complaint, Grievance, and Appeal Coordinator to manage and adjudicate member and provider complaints, grievances, and appeals in a timely manner.

o. A Claims Administrator/Management Information System (MIS) Director.

p. A Compliance Officer to oversee and manage all fraud, waste, and abuse and compliance activities.

2.2.2 The health plan must have a physical presence in Missouri by having one or more offices located in the State. Additionally, the following personnel, at a minimum, shall be located in and operate from the State of Missouri:

a. Health Plan Administrator;
b. Clerical and support staff;
c. Medical Director;
d. Dental Consultant
e. Chief Financial Officer;
f. Quality Assessment and Improvement and Utilization Management Coordinator;
g. Special Programs Coordinator;
h. Case Management Supervisor and Case Management Staff;
i. Behavioral Health Coordinator;
j. Inpatient Certification Review Staff;
k. Member Services Staff;
l. Provider Services Staff;
m. Compliance Officer; and
n. Complaint, Grievance, and Appeal Coordinator.

2.2.3 The health plan shall inform the state agency in writing within seven (7) calendar days of staffing changes in the key positions listed below. The health plan shall fill vacancies in any of these key positions with permanent qualified replacements within ninety (90) calendar days of the departure of the former staff member.

a. Health Plan Administrator;
b. Medical Director;
c. Case Management Supervisor
d. Quality Assessment and Improvement and Utilization Management Coordinator;
e. Special Programs Coordinator;
f. Claims Administrator/Management Information System (MIS) Director;
g. Behavioral Health Coordinator;
h. Compliance Officer; and
i. Chief Financial Officer.

2.2.4 The health plan shall ensure that all staff has appropriate training, education, experience, liability coverage, and orientation to fulfill the requirements of the positions and have met all appropriate licensure requirements.

2.2.5 The health plan shall not knowingly employ as a director, officer, partner, or employee with beneficial ownership of more than five percent (5%) of the health plan's equity; a person 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 pursuant to Executive Order No. 12549 or under guidelines implementing such order; or is an affiliate (as defined in such Act) of such a person. In addition, the health plan shall not have an employment, consulting, or other agreement with such a person described above for the provision of items and services that are significant and material to the health plan's obligations required herein.

2.2.6 In accordance with 45 CFR § 162.410, the health plan shall require each ordering and referring professional providing services to health plan members to have a national provider identifier (NPI). The health plan shall require that the NPI be included in each claim for payment for services submitted to the health plan by an ordering or referring professional.

2.2.7 **Non-Discrimination in Hiring and Provision of Services**:

a. Non-Discrimination and ADA: The health plan shall comply with all federal and state statutes, regulations and executive orders relating to nondiscrimination and equal employment opportunity to the extent applicable to the contract. These include but are not limited to:

1) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color, or national origin (this includes individuals with limited English proficiency) in programs and activities receiving federal financial assistance and Title VII of the Act which prohibits discrimination on the basis of race, color, national origin, sex, or religion in all employment activities;

2) Equal Pay Act of 1963 (P.L. 88-38, as amended, 29 U.S.C. Section 206 (d));

3) Title IX of the Education Amendments of 1972, as amended (20 U.S.C 1681-1683 and 1685-1686) which prohibits discrimination on the basis of sex;

4) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794) and the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.) which prohibit discrimination on the basis of disabilities;

5) The Age Discrimination Act of 1975, as amended (42 U.S.C. 6101-6107) which prohibits discrimination on the basis of age;

6) Equal Employment Opportunity – E.O. 11246, "Equal Employment Opportunity", as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity";

7) Missouri State Regulation, 19 CSR 10-2.010, Civil Rights Requirements;

8) Missouri Governor's E.O. #94-03 (excluding article II due to its repeal);

9) Missouri Governor's E.O. #05-30; and

10) The requirements of any other nondiscrimination federal and state statutes, regulations and executive orders which may apply to the services provided via the contract.

b. The health plan shall incorporate in its policies, administration, and delivery of services the values of:

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

1) Honoring member's beliefs;

2) Being sensitive to cultural diversity; and

3) Fostering in staff and providers attitudes and interpersonal communication styles which respect the member's cultural backgrounds.

c. The health plan shall have specific policy statements on minority inclusion and non-discrimination and procedures to communicate the policy statements and procedures to subcontractors.

d. The health plan shall not discriminate in regard to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the health plan declines to include individual or groups of providers in its network, the health plan shall give the affected providers written notice of the reason for its decision. The health plan's provider selection policies and procedures cannot discriminate against particular providers that serve high risk populations or specialize in conditions that require costly treatment. This section may not be construed to:

1) Preclude the health plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

2) Preclude the health plan from establishing measures that are designed to maintain quality of services, control costs, and are consistent with its responsibilities to members.

2.2.8 All services and functions provided by the health plan or its subcontractors under the contract shall be performed in the United States.

2.3 Cultural Competency:

2.3.1 The health plan shall ensure that all health plan members receive equitable and effective treatment in a culturally and linguistically appropriate manner. The health plan shall exhibit congruent behaviors, attitudes, and policies that come together in a system that enables effective work in cross-cultural situations. The health plan shall adhere to the following standards:

a. The health plan shall ensure that members receive from all providers and staff effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

b. The health plan shall implement strategies to recruit, retain, and promote, at all levels of the organization, a diverse staff and leadership that are representative of the demographic characteristics of regions covered by the contract.

c. The health plan shall ensure that staff, at all levels and across all disciplines, receives ongoing education and training in culturally and linguistically appropriate service delivery.

d. The health plan shall provide to members, in their preferred language, both verbal offers and written notices, when required, informing them of their right to receive language assistance services.

e. The health plan shall make available easily-understood member-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in regions covered by the contract.

f. The health plan shall develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

g. The health plan shall ensure that data on the individual member's race, ethnicity, and spoken and written language are collected in health records, integrated into the health plan's management information systems, and periodically updated.

h. The health plan shall maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of regions covered by the contract.

i. The health plan shall develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and member involvement in designing and implementing culturally and linguistically appropriate services in health care.

j. The health plan shall ensure that the grievance and appeal resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural grievance and appeals by the member.

k. The health plan shall regularly make information available to the public about the health plan's progress and successful innovations in implementing culturally and linguistically appropriate services and provide public notice in their communities about the availability of this information.

2.4 Health Plan Provider Networks:

2.4.1 **General**:

a. The health plan shall establish and maintain health plan provider networks in geographically accessible locations, in accordance with the travel distance standards specified herein. The health plan's network shall consist of, at minimum, hospitals, physicians, advanced practice nurses, behavioral health providers, substance abuse providers, dentists, emergent and non-emergent transportation services, safety net hospitals (including acute care safety net hospitals as defined in 13 CSR 70-15.010 of the Code of State Regulations, as amended), and all other provider types necessary to ensure sufficient capacity to make available all services in accordance with the service accessibility standards specified herein. In order to maintain geographically accessible locations for members, the health plan shall look to providers in contiguous and other counties for full development of the network.

b. In order to ensure that members have access to a broad range of 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.

c. The health plan shall regularly monitor its provider network to ensure that service accessibility standards described herein are being met, that provider listings of panel status (open and closed) are accurate, that members have and use their primary care providers (PCPs), and that emergency rooms are not being used unnecessarily. As part of the monitoring, the health plan shall, at a minimum, require that its providers report on the number of members they will take as patients or the

limitations to the number of referrals accepted and report to the health plan when they have reached eighty-five percent (85%) of capacity. The health plan shall have and implement policies and procedures that describe its network development and monitoring activities, including methods for ensuring adequate capacity for members.

2.4.2 **Primary Care Provider Responsibilities**: The health plan shall have written policies and procedures for all its primary care provider activities required herein. At a minimum, these policies and procedures shall provide for the linking of every member to a primary care provider; the monitoring of primary care providers to ensure they are performing the duties described below and are operating in compliance with health plan policies and procedures described herein; the use of specialists as primary care provider; and notifying primary care providers of their assigned member(s) prior to the member's effective date with the primary care provider.

a. The primary care provider shall serve as the member's initial and most important contact. As such, primary care provider responsibilities must include at a minimum:

1) Maintaining continuity of each member's health care;

2) Making referrals for specialty care and other medically necessary services to both in-network and out-of-network providers;

3) Working with health plan case managers in developing plans of care for members receiving case management services;

4) Conducting a behavioral health screen to determine whether the member needs behavioral health services;

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

5) Maintaining a comprehensive, current medical record for the member, including documentation of all services provided to the member by the primary care provider, as well as any specialty or referral services, diagnostic reports, physical and behavioral health screens, etc.; and

6) Participating in the health plan's case management team, as applicable and medically necessary.

b. Primary care providers may have formalized relationships with other primary care providers to see their members for after-hours care, during certain days, for certain services, or other reasons to extend their practice. Primary care providers may also, in addition to working with the health plan's case managers, provide additional case management support for their members. However, the primary care providers shall be ultimately responsible for the activities listed in this section for the members assigned to them. The health plan shall support the PCP with resources they may have available to which the PCP does not have access.

2.4.3 **Primary Care Providers - Eligible Specialties**: The health plan shall limit its primary care providers to licensed physicians specializing in family and general practice, pediatrics, obstetrics and gynecology (OB/GYN), and internal medicine; and registered nurses who are advanced practice nurses with specialties in family practice, pediatric practice, behavioral health, and OB/GYN practice. To the maximum extent possible, the health plan shall include all of these specialties in its health plan provider network.

2.4.4 **Primary Care Provider Teams and Primary Care Clinics**: The responsibilities of a primary care provider team and a primary care clinic shall be the same as the responsibilities listed herein for primary care providers.

a. If the health plan provider network includes institutions with teaching programs, primary care provider teams (comprised of residents and a supervising faculty physician) may serve as a primary care provider. If primary care provider teams are included within the health plan's provider network, the primary care provider teams may include advanced practice nurses or physician assistants recognized by the Board of Healing Arts who, at the member's discretion, may serve as the point of first contact for the member. In both instances, the health plan shall organize its primary care provider teams so as to ensure continuity of care to members and identify a "lead physician" within the team for each member. The "lead physician" must be an attending physician and not a resident.

b. The health plan may elect to make clinics available to serve as primary care providers. The primary care clinic must provide the range of services required of all primary care providers. A centralized medical record shall be maintained on each member enrolled with the primary care clinic.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

c. The state agency must approve the primary care provider teams' and primary care providers' responsibilities proposed in the Local Community Care Coordination Program (LCCCP) models.

2.4.5 **Primary Care Providers - Selection and Assignment**: The health plan shall offer its members freedom of choice in selecting a primary care provider. The health plan shall decrease the number of members assigned to a primary care provider if necessary to maintain the appointment availability standards described herein. To the degree possible, the health plan shall adjust the primary care provider's member assignments prospectively (before care has been initiated) and the health plan shall take steps to minimize the need for such adjustment to the primary care provider's member assignments.

2.4.6 **Specialists as Primary Care Providers**: The health plan shall allow specialists to serve as primary care providers for members with disabling conditions or chronic conditions which require ongoing care from a specialist so long as the specialist agrees, in writing, to accept the member as a primary care patient and to assume the responsibilities listed herein.

2.4.7 **Physician Specialists**: The health plan shall employ or contract with physician specialists in sufficient numbers to ensure specialty services are available in accordance with travel distance and appointment standards described herein. The health plan shall have protocols for coordinating care between primary care providers and specialists. These protocols shall include the expected response time for consults between primary care providers and specialists.

2.4.8 **Behavioral Health and Substance Abuse Providers**: To ensure a broad range of treatment options are available, the health plan shall include in its network a mix of behavioral health and substance abuse providers with experience in treating children, adolescents, and adults.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

a. The health plan shall include in the health plan provider network, the majority of Community Mental Health Centers (CMHC) within each county included in the Managed Care area where the health plan has covered lives. If there is not a CMHC in that county, the health plan must contract with a CMHC within thirty (30) miles of a county where the health plan has covered lives. If there is not a CMHC within thirty (30) miles of that county, the health plan must contract with a CMHC in the Department of Mental Health (DMH) CMHC catchment area for any county where the health plan has covered lives. A map of the DMH CMHC catchment areas may be found at http://dmh.mo.gov/mentalillness/org/mapofserviceareas.htm. To the maximum extent possible, the health plan shall include all CMHCs in its network. A listing of CMHCs is provided in Exhibit C and in *Federally Qualified Health Clinics, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Family Planning and STD Providers* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/). The health plan shall have protocols for coordinating care between the primary care providers and the CMHC providers. The protocols shall indicate the expected response time for consults between the primary care providers and the CMHC.

b. The behavioral health provider network may include licensed psychiatrists, provisionally licensed psychologists, licensed psychologists, licensed psychiatric advance practice nurses, provisional licensed professional counselors, licensed professional counselors, licensed master social workers, licensed clinical social workers, licensed psychiatric clinical nurse specialists, licensed psychiatric mental health nurse practitioners, licensed home health psychiatric nurse, licensed psychiatric nurse, Missouri certified substance abuse counselors, and Missouri certified behavioral health or substance abuse programs. To be considered adequate, the behavioral health provider network shall, at a minimum, include QBHPs, Qualified Substance Abuse Professionals (QSAP), licensed psychiatrists, licensed psychologists, licensed psychiatric nurses, licensed professional counselors, licensed clinical social workers, and licensed clinical nurse specialists.

1) A QBHP shall be one of the following and provide services within their defined scope of practice:

- A physician, licensed under Missouri State law to practice medicine or osteopathy who has either specialized training in behavioral health services or one (1) year of experience, under supervision, in treating problems related to behavioral health or specialized training.

- A psychiatrist licensed under Missouri State law, who has successfully completed a training program in psychiatry approved by the American Medical Association, the American Osteopathic Association, or other training program identified as equivalent by the state agency.

- A psychologist licensed under Missouri State law to practice psychology with specialized training in behavioral health services.

- A professional counselor licensed under Missouri State law to practice counseling who has specialized training in behavioral health services.

- A clinical social worker licensed under Missouri State law with a Master's Degree in social work from an accredited program who has specialized training in behavioral health services.

- A psychiatric nurse, a registered professional nurse, licensed under Missouri State law who has at least two (2) years of experience in a psychiatric setting or a Master's Degree in psychiatric nursing.

- An individual possessing a Master's Degree or Doctorate Degree in counseling and guidance, rehabilitation counseling and guidance, rehabilitation counseling, vocational counseling, psychology, pastoral counseling, family therapy, social work, or a related field, who has successfully completed a practicum or has one (1) year of experience under the supervision of a QBHP.

- An advanced practice nurse, as set forth in Section 335.011, RSMo, who has had education beyond the basic nursing education and is certified by a nationally recognized professional organization as having a nursing specialty, or who meets criteria for advanced practice nurses established by the Board of Nursing.

2) A QSAP shall demonstrate substantial knowledge and skill regarding substance abuse by being one of the following and must provide services within their defined scope of practice:

- A physician or QBHP who is licensed in Missouri with at least one year of full time experience in the treatment of persons with substance abuse disorders.

- A person who is certified or registered as a substance abuse professional by the Missouri Substance Abuse Counselors Credentialing Board.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

2.4.9 **Federally Qualified Health Centers and Rural Health Clinics**: Federal law requires health plans to include at least one Federally Qualified Health Center (FQHC) in the health plan's provider network. The health plan shall include in the health plan provider network, the majority of FQHCs within each county included in the Managed Care area where the health plan has covered lives. The health plan shall offer a contract to all FQHCs, Provider-Based Rural Health Clinics (PBRHCs) and Independent Rural Health Clinics (IRHCs) at the rates established herein. If there is not an FQHC in the county, the health plan must have a contract with an FQHC within thirty (30) miles of a county where the health plan has covered lives. To the maximum extent possible, the health plan shall include all FQHCs in its network. A description of FQHC and RHC services is in *Federally Qualified Health Center and Rural Health Clinic Services* located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/). A listing of FQHCs and RHCs may be found in Exhibit C and in *Federally Qualified Health Centers, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Local Public Health Agencies, Family Planning and STD Providers* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/). The health plan shall have protocols for coordinating care between the primary care provider and the FQHC and RHC providers. The protocols shall indicate the expected response time for consults between the FQHC, RHC, and the primary care provider.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

2.4.10 **Family Planning and Sexually Transmitted Disease (STD) Treatment Providers**: The health plan shall include Title X and STD providers in its provider network to serve members covered under the comprehensive and extended family planning, women's reproductive health, and sexually transmitted diseases benefit packages. The health plan shall establish an agreement with each Family Planning and STD treatment provider not in the provider network describing, at a minimum, care coordination, medical record management, and billing procedures. The health plan shall allow for full freedom of choice for the provision of these services. A listing of Family Planning and STD treatment providers is provided in Exhibit C and *Federally Qualified Health Centers, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Local Public Health Agencies, Family Planning and STD Providers* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

2.4.11 **Local Public Health Agencies**: The health plan shall include local public health agencies in its provider network for the public health agency services described herein and for other services such as case management and services provided under the LCCC program. A listing of local public health agencies is provided in Exhibit C, *Federally Qualified Health Centers, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Local Public Health Agencies, Family Planning and STD Providers* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/). The health plan should establish an agreement with each local public health agency not in the provider network describing, at a minimum, care coordination, medical record management, and billing procedures. The health plan shall comply with requirements for reimbursement for certain services provided by local public health agencies as specified herein. The health plan shall comply with all statutorily mandated disease and condition reporting requirements, regardless of the site of the service. *Managed Care Provider Coordination with Local Public Health Agencies* located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/) lists the conditions for which the health plan shall report to or cooperate with local public health agencies.

2.4.12 **Network Changes**:

a. The health plan shall notify the state agency within five (5) business days of first awareness/notification of changes to the composition of the health plan provider network or the health care service subcontractors' provider network that materially affect the health plan's ability to make available all covered services in a timely manner. At a minimum, this means the health plan shall notify the state agency when there is:

1) A decrease in the total number of primary care providers by more than five percent (5%);

2) A loss of providers that will result in the health plan failing to meet the service accessibility standards defined herein and in 20 CSR 400-7.095;

3) A loss of any hospital regardless of whether the loss will result in the health plan failing to meet the service accessibility standards defined herein and in 20 CSR 400-7.095;

4) Any other adverse change to the composition of the provider network which impairs or denies the members adequate access to in-network providers, including but not limited to reporting to the state agency when a provider has reached eighty-five percent (85%) of capacity;

AMENDMENT 1 DELETED THE FOLLOWING PARAGRAPH:

5) DELETED

AMENDMENT 1 DELETED THE FOLLOWING PARAGRAPH:

6) DELETED

BAFO 001 REVISED THE FOLLOWING PARAGRAPH.

b. If a primary care provider ceases participation in the health plan's provider network, the health plan shall send written notices to the members who have chosen or are assigned to that provider as their primary care provider. The health plan shall mail this notice, with information about how to select a new primary care provider, at least thirty (30) calendar days prior to the effective date of the termination.

BAFO 001 REVISED THE FOLLOWING PARAGRAPH.

c. If a member is in a prior-authorized, ongoing course of treatment with any other participating provider who becomes unavailable to continue to provide services, the health plan shall notify the member in writing at least thirty (30) calendar days prior to the effective date of the termination.

d. The requirements to provide notice prior to the effective dates of termination shall be waived in instances where a provider (1) becomes physically unable to care for members due to illness, (2) dies, (3) relocates outside of the region, (4) fails to notify the health plan, or (5) fails credentialing. Under these circumstances, the health plan shall issue the notice immediately upon becoming aware of the circumstances.

e. The health plan shall have procedures to address changes in its provider network that negatively affect the ability of members to access services, including access to a culturally diverse provider network. Material changes in network composition that negatively affect member access to services may be grounds for contract cancellation or State determined sanctions.

2.4.13 **Mainstreaming**: The state agency considers mainstreaming of MO HealthNet Managed Care members into the broader health delivery system to be important. The health plan therefore shall ensure that all of the in-network providers accept members for treatment and that in-network providers do not intentionally segregate members in any way from other persons receiving services.

a. 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, gender, religion, age, national origin, ancestry, marital status, sexual orientation, 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:

1) Denying or not providing to a member any covered service or availability of a facility;

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; and

3) Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service.

b. 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), the State 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 the health plan's existing subcontractors' failure to comply with this section and does not take action to correct such within thirty (30) calendar days, the State shall consider the health plan to have breached the provisions and requirements of the contract.

2.4.14 **Home Health Agencies**: The health plan shall comply with any applicable Federal requirements with respect to home health agencies, as amended. Federal regulations regarding home health agencies are available via the Internet at www.ecfr.gov (42 Code of Federal Regulations (CFR) 484, Subpart A, B, C and 42 CFR 441.15).

2.4.15 **School Based Dental Services**: The health plan shall contract with and reimburse any licensed dental provider who provides preventive dental services (i.e., dental exams, prophylaxis, and sealants) in a school setting. The health plan shall ensure that dental providers who participate in the health plan's provider network are qualified under the credentialing criteria of the health plan and are willing to accept the health plan's operating terms, including but not limited to, the health plan's fee schedule, covered expenses, and quality standards. Nothing shall prevent a health plan from instituting reasonable credentialing criteria for school-based dental services or establishing other reasonable measures designed to maintain quality of care or control costs.

2.4.16 **Tertiary Care**: Tertiary care is defined as health services provided by highly-specialized providers, such as medical sub-specialists. These services frequently require complex technological and support facilities. The health plan shall provide tertiary care services including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day in the regions covered by the contract. If the health plan does not have a full range of tertiary care services, the health plan shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers.

2.4.17 **Specialty Pediatric Hospitals**: The health plan shall include specialty pediatric hospitals as defined in 13 CSR 70-15.010 (2) (P), as amended, in its provider network.

2.5 Service Accessibility Standards:

2.5.1 **Twenty-Four Hour Coverage**:

a. The health plan shall ensure that emergency medical/behavioral health services are available twenty-four (24) hours seven (7) days per week to treat an emergency medical condition.

b. The health plan shall provide an accommodation, if needed, to ensure all members equal access to twenty-four (24) hours per day health care coverage.

2.5.2 **Travel Distance**: The health plan shall comply with travel distance standards as set forth by the Department of Insurance, Financial Institutions & Professional Registration in 20 CSR 400-7.095 as amended, and in *Travel Distance Standards* located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/). For those providers not addressed under 20 CSR 400-7.095, the health plan shall ensure that members have access to those providers within thirty (30) miles, unless the health plan can demonstrate to the state agency that there is no such licensed provider within thirty (30) miles, in which case the health plan shall ensure members have access to those providers within sixty (60) miles. For those providers addressed under 20 CSR 400-7.095 but not applicable to the MO HealthNet Managed Care Program (e.g. chiropractors), the health plan shall not be held accountable for the travel distance standards for those providers.

2.5.3 **Appointment Standards**:

a. The health plan shall ensure that waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments do not exceed one hour from the scheduled appointment time.

b. In accordance with State requirements specified at 20 CSR 400-7.095, Exhibit A, the health plan shall adhere to appointment standards for all provider types. The health plan shall have in its network the capacity to ensure that the time elapsed between the request for appointments and the scheduled appointment does not exceed the following:

1) Urgent care appointments for illness injuries which require care immediately but do not constitute emergencies (e.g. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services): Appointments within twenty-four (24) hours.

2) Routine care with symptoms (e.g. persistent rash, recurring high grade temperature, nonspecific pain, fever): Appointments within one (1) week or five (5) business days whichever is earlier.

3) Routine care without symptoms (e.g. well child exams, routine physical exams): Appointments within thirty (30) calendar days.

4) Behavioral health and substance abuse services: Aftercare appointments within seven (7) calendar days after hospital discharge.

In addition to the appointment standards for behavioral health and substance abuse services required under 20 CSR 400-7.095, Exhibit A, the health plan shall also have in its network the capacity to ensure the following standards:

- Urgent care appointments which require care immediately but do not constitute emergencies: Appointments within seventy-two (72) hours;
- Routine care with or without symptoms within two (2) weeks.

c. For maternity care, the health plan shall be able to provide initial prenatal care appointments for enrolled pregnant members as follows:

1) First trimester appointments must be available within seven (7) calendar days of first request.

2) Second trimester appointments must be available within seven (7) calendar days of first request.

3) Third trimester appointments must be available within three (3) calendar days of first request.

4) Appointments for high risk pregnancies must be available within three (3) calendar days of identification of high risk to the health plan or maternity care provider, or immediately if an emergency exists.

d. The health plan shall have policies and procedures in accordance with 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.

2.5.4 **Access Plan**: In accordance with State requirements specified at 20 CSR 400-7.095, the health plan shall file an annual (March 1 of each year) access plan with the Department of Insurance, Financial Institutions and Professional Registration that describes the adequacy of its provider network, measures to adhere to access standard requirements, and measures to address identified access issues.

2.5.5 **Prior Authorization**:

a. The health plan is prohibited from requiring prior authorization for emergency medical/behavioral health or substance abuse services as defined herein.

b. The health plan's prior authorization policy, procedures, and practices shall comply with The Wellstone – Domenici Mental Health Parity and Addiction Equality Act of 2008 and 45 CFR Parts 146 and 147.

c. The health plan shall specify, in writing, the procedures for prior authorization of non-emergency services and the timeframes in which authorizations will be processed (approved or denied) and providers and members are notified.

d. If the health plan requires a referral, assessment, or other requirement prior to the member accessing requested medical, behavioral health, or substance abuse services, such requirements shall not be an impediment to the timely delivery of the medically necessary service. The health plan shall assist the member to make any necessary arrangements to fulfill such requirements (e.g. scheduling appointments, providing comprehensive lists of available providers, etc.). If such arrangements cannot be made timely, the requested services shall be approved.

e. The health plan shall have and implement prior authorization policies and procedures that meet the following minimum requirements:

1) All appeals and denials must be reviewed by a professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

2) There is a set of written criteria for review based on sound medical evidence that is updated regularly and consistently applied and for consultations with the requesting provider when appropriate.

3) Reasons for decisions are clearly documented and assigned a prior authorization number which refers to and documents approvals and denials.

4) Documentation shall be maintained on any alternative service(s) approved in lieu of the original request.

5) There is a well-publicized review process for both providers and members.

6) The review process is completed and communicated to the provider in a timely manner, as indicated below, or the denials shall be deemed approved. For the purpose of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

- Approval or denial of non-emergency services, when determined as such by emergency room staff, shall be provided by the health plan within thirty (30) minutes of request.

- Approval or denial shall be provided within twenty-four (24) hours of request for services determined to be urgent by the treating provider.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

- Approval or denial shall be provided within thirty-six hours, which shall include one (1) working day, of obtaining all necessary information for routine services. The health plan shall notify the requesting provider within thirty-six hours, which shall include one (1) working day, following the receipt of the request of service regarding any additional information necessary to make a determination. In no case shall a health plan exceed fourteen (14) calendar days following the receipt of the request of service to provider approval or denial.

- Involuntary detentions (ninety-six (96) hour detentions or court ordered detentions) or commitments shall not be prior authorized for any inpatient days while the order of detention or commitment is in effect.

f. The health plan shall ensure that members are not without necessary medical supplies, oxygen, nutrition, etc., and shall have written procedures for making an interim supply of an item available.

g. The health plan shall ensure that the member's treatment regimens are not interrupted or delayed (e.g. physical, occupational, and speech therapy; psychological counseling; home health services; personal care, etc.) by the prior authorization process.

h. The health plan is responsible for payment of custom items (e.g. custom or power wheelchairs, eyeglasses, hearing aids, dentures, custom HCY/EPSDT equipment, or augmentative communication devices) that are delivered or placed within six (6) months of approval, even if the member's enrollment in the health plan ends.

i. If the health plan prior authorizes health care services, the health plan shall not subsequently retract its authorization after the services have been provided, or reduce payment for an item or service unless:

1) The authorization is based on material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or
2) The health plan's contract terminates before the health care services are provided; or
3) The covered person's coverage under the health plan terminates before the health care services are provided.

j. The health plan shall not deny physician requested continuing coverage of an inpatient hospital stay unless an alternative service is recommended by the health plan and such alternative care is available and has been scheduled within seven (7) days of discharge and is appropriate to meet the medical needs of the member.

2.5.6 **Certification Review**:

a. The health plan shall have written policies and procedures that specify the steps for obtaining initial, concurrent, and retrospective reviews for inpatient admissions and the timeframes in which

authorizations will be processed (approved or denied) and providers and members are notified. The health plan shall ensure that these policies and procedures meet the following minimum requirements:

1) A professional with experience or expertise comparable to the provider requesting the authorization reviews all appeals and denials.

2) There are standard policies and procedures for inpatient hospital admissions, continued stay reviews, and retrospective reviews and for making determinations on certifications or extensions of stays based on sound medical evidence that is updated regularly and consistently applied and for consultations with the requesting provider when appropriate.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

- For inpatient hospital admissions, continued stay reviews, and retrospective reviews to specialty pediatric hospitals, the health plan shall use the same criteria as MO HealthNet Fee-For-Service Program found in section 13.29.d.1 of the Hospital Provider Manual on the state agency website: http://www.dss.mo.gov/mhd.

- For psychiatric inpatient hospital admissions, continued stay reviews, and retrospective reviews, the health plan shall use LOCUS/CALOCUS. If the member scores less than an inpatient level of care on the LOCUS/CALOCUS but the services recommended are not available, the health plan shall continue to authorize inpatient care. In the event of disagreement, the health plan shall provide full detail of its scoring of the LOCUS/CALOCUS to the provider of service.

- The health plan's certification review policy, procedures, and practices shall comply with The Wellstone – Domenici Mental Health Parity and Addiction Equality Act of 2008 and 45 CFR Parts 146 and 147.

3) Reasons for decisions are clearly documented and assigned a certification number, which refers to and documents approvals and denials.

4) Documentation is maintained on any alternative service approved in lieu of the original request.

5) There are fair and unbiased policies and procedures for reconsideration requests when the attending physician, the hospital, or the member disagrees with the health plan's determination regarding inpatient hospital admission or continued stays.

6) There are policies and procedures followed to address the failure or inability of a provider or a member to provide all necessary information for review. In cases where the provider or a member will not release necessary information, the health plan may deny certification of an admission.

7) There is a well-publicized review process for both providers and members.

8) To the extent known, the health plan shall inform inpatient providers of the member's recent health care service history at the time of authorization of a psychiatric inpatient admission. Such information shall include psychiatric inpatient admissions and emergency room visits for the prior year, psychiatric outpatient services for the prior six (6) months, and medications for the prior ninety (90) calendar days. The date, diagnosis, provider, and procedure shall be provided for each episode of care. Services related to substance abuse or HIV disorders are exempt from this requirement. Claims history from CyberAccess[sm] may be used to fulfill this requirement.

b. The review process shall be completed and communicated to the provider and member in a timely manner, as indicated below or the denials shall be deemed approved. For the purpose of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

1) Approval or denial for initial determinations shall be provided by the health plan within thirty-six hours, which shall include one (1) working day, of obtaining all necessary information.

2) Approval or denial for concurrent review determinations shall be provided by the health plan within one (1) working day of obtaining all necessary information.

3) Approval or denial for retrospective review determinations shall be provided by the health plan within thirty (30) working days of receiving all necessary information.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

4) The health plan shall notify the requesting provider within thirty-six hours, which shall include one (1) working day, following the receipt of the request of service regarding any additional information necessary to make a determination.

5) In no case shall a health plan exceed fourteen (14) calendar days following the receipt of the request of service to provide approval or denial for an initial or concurrent review.

2.5.7 **Behavioral Health and Substance Abuse In-Network Self Referrals**: The health plan shall have written policies and procedures that permit members to seek in-network behavioral health services and substance abuse services without a referral or authorization from the primary care provider. The policies and procedures shall permit members to contact an in-network behavioral health and substance abuse provider directly and shall provide for the authorization of at least four (4) visits annually without prior authorization requirements. The health plan shall require that the health plan's behavioral health and substance abuse providers complete a health status screen, at the initial point of contact and as part of the re-assessment process for members in treatment. The health plan shall require the health plan's behavioral health and substance abuse providers to refer members with physical health conditions (as indicated by the screen) to their primary care provider for evaluation and treatment of the physical health condition.

2.5.8 **Direct Access and Standing Referrals**:

a. The health plan shall have direct access and standing referral policies and procedures that address how a member, including but not limited to those with special health care needs, may request and obtain:

1) A referral to an out-of-network provider when the health plan does not have a health care provider in the network with appropriate training or experience to meet the particular health care needs of the member;

2) A standing referral from a specialist if the member has a condition which requires on-going care from a specialist; and

3) Access to a specialty care center if the member has a life-threatening condition or disease either of which requires specialized medical care over a prolonged period of time.

b. In accordance with State law, the health plan shall allow members direct access to the services of the in-network OB/GYN of their choice for the provision of covered services.

2.5.9 **Transition of Care**: Regarding transition of care for newly enrolled members transitioning to the health plan from fee-for-service or another health plan and for members transitioning out of the health plan to another health plan, the health plan shall, at a minimum, carry out the following responsibilities:

a. Provide for the transfer of relevant member information, including medical records and other pertinent materials, to another health plan upon notification of establishment of care such that the transition of care shall be smooth. Upon contract award, the health plan shall provide the state agency with a contact person for transition of care information.

1) If a member enrolls with the health plan from another health plan, the health plan shall, within five (5) business days from the date of the state agency's notification to the health plan of the member's anticipated enrollment date, contact the member to determine the name of the other health plan in order to request relevant member information from the other health plan.

2) If the health plan is contacted by a member's new health plan requesting relevant member information, the health plan shall provide such data to the health plan within five (5) business days of receiving the request. Claims history from CyberAccess[sm] may be used to fulfill this requirement.

3) If the health plan becomes aware that a member will transfer to another health plan, the health plan shall contact the other health plan within five (5) business days of becoming aware of the member's transfer and shall share relevant member information and respond to questions regarding the member's care needs and services.

4) If the health plan receives new members who were previously fee-for-service, the health plan must contact the member's provider within 5 business days of the state agency's notification to the health plan of the member's anticipated enrollment date, to request the necessary medical records and information. Claims history from CyberAccess[sm] may supplement the medical record and information from the member's provider.

b. Provide care coordination for prescheduled health services, access to preventive and specialized care, case management, member services, and education with minimal disruption to members' established relationships with providers and existing care treatment plans.

1) If the health plan changes subcontractors, the health plan shall ensure that relevant member information is transferred between the subcontractors within a timely manner prior to transitioning to the new subcontractor.

c. Work with an out-of-network provider and/or the previous health plan to affect a smooth transfer of care to appropriate in-network providers when a newly enrolled member has an existing relationship with a physical health, behavioral health, or substance abuse provider that is not in the health plan's network. At a minimum, the health plan shall (1) facilitate the securing of a member's records from the out-of-network providers as needed, and (2) pay rates comparable to fee-for-service for these records, unless otherwise negotiated.

d. Facilitate continuity of care for medically necessary covered services. In the event a member entering the health plan is receiving medically necessary covered services, in addition to or other than prenatal services (see below for members in their third trimester receiving prenatal services), the day before enrollment into the health plan, the health plan shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by in-network or out-of-network providers.

1) The health plan shall provide continuation of such services for the lesser of (1) sixty (60) calendar days, or (2) until the member has transferred, without disruption of care, to an in-network provider.

2) For members eligible for case management, the new health plan shall provide continuation of services authorized by the prior health plan for up to sixty (60) calendar days after the member's enrollment in the new health plan and shall not reduce services until an assessment is conducted by the new health plan.

e. Ensure that any member entering the health plan is held harmless by the provider for the costs of medically necessary covered services except for applicable MO HealthNet cost sharing.

f. Allow non-pregnant members receiving a physician authorized course of treatment to continue to receive such treatment, without any form of prior authorization and without regard to whether such services are being provided by in-network or out-of-network providers, for the lesser of sixty (60) calendar days or until the member has been seen by the assigned primary care provider who has authorized a course of treatment.

g. Allow members in their third trimester of pregnancy to continue to receive services from their prenatal care provider (whether in-network or out-of-network), without any form of prior authorization, through the postpartum period (defined as sixty (60) calendar days from date of birth).

h. Allow pregnant members to continue to receive services from their behavioral health and/or substance abuse treatment provider, without any form of prior authorization, until the birth of the child, the cessation of pregnancy, or loss of eligibility.

i. Ensure that inpatient and residential treatment days are not prior authorized during transition of care.

j. Have written policies and procedures that address all transition of care requirements herein.

2.6 Payments to Providers:

2.6.1 The health plan shall negotiate mutually acceptable payment rates and payment timeframes with providers so long as those rates and timeframes are in compliance with the requirements in RSMo 376.383 and RSMo 376.384, as amended. Regardless of the specific arrangements the health plan makes with providers, the health plan shall make timely payments to both in-network and out-of-network providers, subject to the conditions described below.

2.6.2 All disputes between the health plan and in-network and out-of-network providers shall be solely between such providers and the health plan. In the case of any disputes regarding payment for covered services between the health plan and providers, the member shall not be charged for any of the disputed costs except as allowed for below.

2.6.3 In accordance with 13 CSR 70-4.0301, the health plan shall ensure that providers accept payment from the health plan as payment in full (no balance billing) and not collect payment from members except for applicable MO HealthNet cost sharing amounts.

2.6.4 When services are not in the comprehensive benefit package or in the Additional Health Benefits section of the contract, and, prior to providing the services, the provider informed the member that the services were not covered. The provider shall inform the member of the non-covered service and have the member acknowledge the information. If the member still requests the service, the provider shall obtain such acknowledgement in writing (private pay agreement) prior to rendering the service. Regardless of any understanding worked out between the provider and the member about private payment, once the provider bills the health plan for the service that has been provided, the prior arrangement with the member becomes null and void. The health plan shall reference the contract provisions regarding payment to out-of-network providers.

2.6.5 **Retroactive Eligibility Period**: Except for newborns, the health plan shall not be responsible for any payments owed to providers for services rendered prior to a member's enrollment with the health plan, even if the date of service fell within an established period of retroactive MO HealthNet eligibility.

2.6.6 **Claims Processing Requirements**: The claim processing requirements are set forth by RSMo 376.383 and RSMo 376.384, as amended. For the purposes of this contract, a clean claim means a claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

2.6.7 **Inappropriate Payment Denials**: If the health plan has a pattern of inappropriately denying or delaying payments for services, the health plan may be subject to suspension of new enrollments, withholding in full or in part the capitation payments, contract cancellation, or refusal to contract in a future time period. This applies not only to situations where the state agency has ordered payment after appeal but to situations where no appeal has been made (i.e., the state agency is knowledgeable about the documented abuse from other sources).

2.6.8 **Federally Qualified Health Centers (FQHCs), Provider-Based Rural Health Clinics (PBRHCs), and Independent Rural Health Clinics (IRHCs)**: FQHCs, PBRHCs, and IRHCs are entitled to reimbursement of reasonable costs from the state agency and any differential payment from the state agency.

a. The health plan shall reimburse the FQHCs and PBRHCs ninety percent (90%) of their allowable Medicaid billed charges.

b. The health plan shall reimburse IRHCs ninety percent (90%) of their Medicare/Medicaid interim rate per visit. The state agency will provide the IRHC's Medicare/Medicaid interim rate to the health plans annually or upon request by the health plan.

c. The state agency shall perform reconciliation between the health plan reimbursement and the FQHC's/PBRHC's/IRHC's reasonable costs for the covered services provided under the contract. The FQHC/PBRHC/IRHC must fully comply with the state agency's payment and billing systems, and provide the state agency with all cost reporting information required by the state agency to verify reasonable costs and apply applicable reasonable cost reimbursement principles.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

d. The health plan shall submit a list of its contracted FQHCs, PBRHCs, IRHCs and CMHCs to the state agency annually at the start of each contract period. A listing may be found in Exhibit C and in *Federally Qualified Health Centers, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Local Public Health Agencies, Family Planning and STD Providers* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

e. The health plan shall follow the billing instructions found in the Companion Guide on the state agency's website: http://www.dss.mo.gov/mhd/providers/index.htm. The health plan shall include the health plan paid amount when the health plan submits encounter claims to the state agency.

f. Health plan records applicable to a FQHC/PBRHC/IRHC are subject to audit by the state agency or its contracted agent.

BAFO 001 AND AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

2.6.9 **Community Mental Health Centers**: CMHCs are designated entry and exit points for mental health services and are required to provide a comprehensive array of services to patients in their designated service areas who seek care. To recognize the CMHCs' higher costs of doing business and their role as safety net providers, the health plan shall reimburse CMHCs the rate of 1.36 times the Medicare rate for such services. The capitation rate includes this reimbursement methodology. The full amount of this

reimbursement shall be passed to the CMHC. The state agency will conduct an annual audit of the health plan to ensure the reimbursement is passed to the CMHC. To qualify for this level of reimbursement, CMHCs must be Medicare certified, and also approved by the Department of Mental Health. An example of this level of reimbursement is in *Community Mental Health Clinic Reimbursement* located on the MO HealthNet Division website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/).

2.6.10 **Local Public Health Agencies**: The health plan shall reimburse the local public health agency (both in-network and out-of-network) according to the most current MO HealthNet program fee schedule in effect at the time of service, unless otherwise negotiated.

2.6.11 **Payment for Emergency Services and Post-stabilization Care Services**:

a. The health plan shall cover and pay for emergency services regardless of whether the provider is an in-network or out-of-network provider.

   1) The state agency encourages the health plan and providers to reach agreement on payment for services.

   2) The health plan shall pay out-of-network providers for emergency services at the current MO HealthNet program rates in effect at the time of service.

b. The state agency and the health plan shall not reimburse for emergency services provided outside the United States.

c. The health plan shall not deny payment for treatment obtained under either of the following circumstances:

   1) A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition specified herein; or

   2) A representative of the health plan instructs the member to seek emergency services.

d. 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 provider or the health plan of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.

e. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

f. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the health plan.

g. The health plan shall be financially responsible for post-stabilization care services, obtained within or outside the health plan, that are pre-approved by a health plan provider or other health plan representative.

h. The health plan shall be financially responsible for post-stabilization care services, obtained within or outside the health plan, that are not pre-approved by a health plan provider or other health plan representative, but are administered to maintain, improve, or resolve the member's stabilized condition if:

1) The health plan does not respond to a request for pre-approval within thirty (30) minutes;

2) The health plan cannot be contacted; or

3) The health plan representative and the treating physician cannot reach an agreement concerning the member's care and a health plan physician is not available for consultation. In this situation, the health plan shall give the treating physician the opportunity to consult with a health plan physician and the treating physician may continue with care of the member until a health plan physician is reached or one of the criteria in the subparagraph below is met.

i. The health plan's financial responsibility for post-stabilization care services which the health plan has not pre-approved ends when:

1) A health plan physician with privileges at the treating hospital assumes responsibility for the member's care;

2) A health plan physician assumes responsibility for the member's care through transfer;

3) A health plan representative and the treating physician reach an agreement concerning the member's care; or

4) The member is discharged.

j. The health plan shall limit charges to members for post-stabilization care services to an amount no greater than what the health plan would charge the member if he or she had obtained the services through the health plan.

k. The health plan shall negotiate mutually acceptable payment rates with out-of-network providers for post-stabilization services for which the health plan has financial responsibility.

2.6.12 **Fee Schedule for Dental, Optical, and Physician Services**: The Missouri 94th General Assembly approved a statutory change for the state agency to develop a four-year plan to achieve parity with Medicare reimbursement rates for physicians and approved a fee increase for the MO HealthNet dental and optical services. The statutory change affects MO HealthNet Managed Care health plans' reimbursement rates. Since the Missouri General Assembly appropriated funds expressly for the services required herein, the health plan shall pass fee increases to its providers commensurate with the Missouri General Assembly's intent. The health plan shall maintain the fee schedule for dental, optical, and physician services at no lower than the MO HealthNet Fee-For-Service fee schedule in effect at the time of service for the codes that had a fee effective date of July 1, 2007 or later in the programs described below. The MO HealthNet Online Fee-For-Service Fee Schedule is available electronically at the state agency's website: http://www.dss.mo.gov/mhd/providers/pages/cptagree.htm.

a. The dental program includes examinations, evaluations, treatments, and preventive pediatric and adult dental health including but not limited to fluoride treatment, gingivectomy, pulp treatment, root canal therapy, sealants, x-rays, and children's orthodontia.

b. The optical program provides eye examinations, serial tonometry, lenses and frames, a prosthetic eye, orthoptic and/or pleoptic training, and contact lenses.

c. The physician program includes services provided by medical personnel in a physician's office, a hospital, an outpatient facility, or nursing home that include medical examinations, anesthesia services, surgery, radiology, transplants, psychiatry, dialysis, ophthalmology, otorhinolaryngology, cardiovascular, physical medicine, nervous system, digestive system, obesity, obstetrics, case management, diabetes self-management training, podiatry, and pathology.

2.6.13 **Specialty Pediatric Hospitals:** The health plan shall reimburse specialty pediatric hospitals as defined in 13 CSR 70-15.010 (2) (P) at no lower than the MO HealthNet Fee-For-Service fee schedule in effect at the time of service unless otherwise negotiated with the provider.

2.6.14 **Services Delivered Outside Health Plan's Regions**: The health plan shall pay for services furnished outside the regions covered by the contract if the services are furnished to a member and any of the following conditions are met:

a. Medical services are needed because of an emergency medical condition;

b. Medical services are needed and the member's health would be endangered if he or she were required to travel to his or her residence; or

c. On the basis of medical advice, the health plan determines that the needed medical services, or necessary supplementary resources, are more readily available outside the region. These services are subject to the health plan's prior authorization and concurrent review process.

2.6.15 **Electronic Health Record (EHR) Incentives**: The state agency has implemented incentive payments for "eligible professionals" who adopt, implement, upgrade, or meaningfully use certified electronic health record technology. For purposes of this section, "eligible professional" has the definition set forth in Section 1903(t)(3)(B) of the Act. In general, eligible professionals are physicians, pediatricians, dentists, certified nurse midwives, nurse practitioners, and some physician's assistants who meet a minimum Medicaid patient volume threshold. Incentive payment amounts shall be determined by Section 1903(t)(5) of the Act.

2.6.16 **Coverage of Preventive Health Services**:

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

a. Federal Law, Section 2713 of the Public Health Act requires non-grandfathered health plans to provide, at a minimum, coverage without cost-sharing for preventive services rated 'A' or 'B' by the U.S. Preventive Services Force (http://www.uspreventiveservicestaskforce.org). For guidance on coordination of benefits for these services, see the Third Party Liability section herein.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

b. DELETED.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

2.6.17 **Ambulance Reimbursement**: The Missouri 97th General Assembly approved reimbursement increase for ground ambulance base codes for basic life support and advanced life support, and for payment of ground ambulance mileage during patient transportation from mile zero to the fifth mile. Since the Missouri General Assembly appropriated funds expressly for these services, the health plan shall pass this increase to its provider's commensurate with the Missouri General Assembly's intent.

2.7 Comprehensive Benefit Package:

2.7.1 The health plan shall provide all covered medical and behavioral health services in the comprehensive benefit package for each member as of the effective date of coverage. The health plan shall provide covered services under this contract in the United States, including the District of Columbia, the Northern Mariana Islands, American Samoa, Guam, Puerto Rico, and the Virgin Islands. The health plan is prohibited from providing payments for items or services provided under the contract to any financial institution or entity located outside the United States. The health plan shall provide services according to the medical and behavioral health needs of the member.

2.7.2 The health plan's services shall comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (45 CFR 146), which requires parity between mental health or substance abuse use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan.

2.7.3 The health plan may manage specific services as long as the health plan provides services that are medically necessary. The health plan shall have a process for allowing exceptions that are in accordance with 13 CSR 70-2.100. The health plan may develop criteria by which it reviews future treatment options, sets prior authorization criteria, or exercises other administrative options for the health plan's administration of medical and behavioral health care benefits. The health plan may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. The health plan shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The health plan shall follow the requirements outlined in the Managed Care Policy Statements, *MO HealthNet Managed Care Policy Statements,* located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/).

2.7.4 **Preventable Serious Adverse Events Performed by Providers**: Services falling in a preventable serious adverse event category shall be denied MO HealthNet reimbursement. The state agency will be following CMS guidelines regarding preventable serious adverse events. A member shall not be liable for payment for any item or service related to a preventable serious adverse event.

2.7.5 The health plan shall include the following services within the comprehensive benefit package and as outlined in the *MO HealthNet Managed Care Policy Statements* located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/):

a. Ambulatory surgical center, birthing center;

b. Behavioral health and substance abuse services:

1) For children covered under MO HealthNet Managed Care within Category of Aid 4 and with dual diagnoses (physical and behavioral/substance use-related), the health plan shall be financially responsible for all inpatient hospital days if the primary, secondary, or tertiary diagnosis is a combination of physical and behavioral/substance use-related health. These admissions are subject to the prior authorization and concurrent review process identified by the health plan. The health plan shall not be responsible for all other behavioral health and substance abuse services for children within Category of Aid 4.

2) For all other members, the health plan shall provide all medically necessary behavioral health and substance abuse services included in the comprehensive benefit package. The state agency, in conjunction with the Department of Mental Health, has developed community-based services with an emphasis on the least restrictive setting. The health plan shall consider, when appropriate, using such services in lieu of using an out-of-home placement setting for members. Services which the health plan shall provide shall include, but not be limited to:

- Inpatient hospitalization, when provided by an acute hospital, or private or state psychiatric hospital.

- Outpatient services when provided by a licensed psychiatrist, licensed psychologist, provisionally licensed psychologist, licensed clinical social worker, provisional licensed clinical social worker, licensed professional counselor, provisional licensed professional counselor, licensed psychiatric advanced practice nurse, licensed home health psychiatric

nurse, or Missouri certified behavioral health or substance abuse program. These services must include outreach efforts on an as needed basis that recognize the unique behavioral health challenges of some members. These efforts may include phone contacts and home visits.

- Crisis intervention/access services, including but not limited to (1) intake, evaluation, and referral services, including services that are alternatives to out of the home placements, and (2) mobile crisis teams for on-site interventions.

- Alternative services which are reasonable, cost effective, and related to the member's treatment plan.

- Referral for screening to receive case management services.

3) With the member's or the member's parent/guardian's consent, the health plan shall notify the member's primary care provider when a member is admitted for behavioral health or substance abuse services.

4) The health plan shall have and implement protocols for coordinating the diagnosis, treatment, and care between primary care providers, behavioral health and substance abuse providers, and assigned case managers. These protocols shall include the expected response time for consults between primary care providers and behavioral health and substance abuse providers.

5) The health plan shall provide behavioral health and substance abuse services defined herein that are court ordered, ninety-six (96) hour detentions, and for involuntary commitments.

6) Behavioral Health Out-of-Network Referrals: If the health plan believes that a child or youth may require residential services in order to receive appropriate care and treatment for a serious emotional disorder, the health plan may apply to the Missouri Division of Comprehensive Psychiatric Services (CPS) for placement in accordance with the state agency's Managed Care policy statement entitled, *Behavioral Health and Substance Abuse Fee-For-Service*.

c. Dental services related to trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury, and dental services when the absence of dental treatment would adversely affect a pre-existing medical condition.

d. Durable medical equipment including but not limited to: orthotic and prosthetic devices, respiratory equipment and oxygen, enteral and parenteral nutrition, wheelchairs and walkers, diabetic supplies and equipment, and medically necessary equipment and supplies used in connection with physical, occupational, and speech therapies for all members with an Individualized Educational Program (IEP) or Individualized Family Service Plan (IFSP).

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

e. Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT): The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that Medicaid cover all medically necessary services listed in Section 1905 (a) of the Act to children from birth through age twenty (20). Independent foster care adolescents with a Medical Eligibility code of 38 and who are ages 21 through 25 will receive a comprehensive benefit package for children in State care and custody, however, EPSDT screenings will no longer be covered. In Missouri, this program is known as the Healthy Children and Youth (HCY) Program. In accordance with the health plan's written policies and procedures, the health plan shall conduct outreach and education of children eligible for the HCY/EPSDT program, provide the full HCY/EPSDT services to all eligible children and young adults under the age of twenty-one (21), and conduct and document well child visits (screenings) using the state agency's HCY/EPSDT screening form as amended. (The HCY screening form may be found on the Internet at: http://manuals.momed.com/ under MO HealthNet Manuals, Forms,

Healthy Children and Youth Screening [HCY Screening].) The health plan shall provide the full scope of HCY/EPSDT services in accordance with the following:

1) The health plan shall ensure HCY/EPSDT well child visits are conducted on all eligible members under the age of twenty-one (21) to identify health and developmental problems. The state agency recognizes that the decision to not have a child screened is the right of the parent or guardian of the child. The health plan shall follow the state agency's Fee-For-Service policies for recognition of completion of all components of a full medical HCY/EPSDT well child visit service. A full HCY/EPSDT well child visits includes all of the components listed below. Segments of the full medical screen (partial screens) may be provided by different providers. An interperiodic screen is defined as any encounter with a health care professional acting within his or her scope of practice.

   - A comprehensive health and developmental history including assessment of both physical and behavioral health developments;
   - A comprehensive unclothed physical exam;
   - Health education (including anticipatory guidance);
   - Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated);
   - Appropriate immunizations according to age;
   - Annual verbal lead risk assessment beginning at age six (6) months and continuing through age seventy-two (72) months using the HCY Lead Risk Assessment Guide Questionnaire that may be obtained at: http://health.mo.gov/living/environment/lead/pdf/HCYLeadRiskAssessmentGuide.pdf;
   - Blood lead level testing is mandatory at twelve (12) and twenty-four (24) months of age for all MO HealthNet children or annually for all children six (6) months to seventy-two (72) months of age if residing in an area designated as high risk for lead poisoning in Missouri as defined by Department of Health and Senior Services regulation 19 CSR 20-8.030;
   - Hearing screening;
   - Vision screening; and
   - Dental screening (oral exam by primary care provider as part of comprehensive exam). Recommended that preventive dental services begin at age six (6) through twelve (12) months and be repeated every six (6) months.

2) If a suspected problem is detected during a well child visit, the child must be evaluated as necessary, using the required assessment protocol, for further diagnosis. This diagnosis is used to determine treatment needs.

3) HCY/EPSDT requires coverage for all follow-up diagnostic and treatment services deemed medically necessary to ameliorate (defined as "prevent from worsening") defects, physical and behavioral health issues, and conditions discovered by the screening services or correct a problem discovered during an HCY/EPSDT visit. All medically necessary diagnosis and treatment services must be provided as long as they are permitted under the Medicaid statute, whether or not they are covered under the State's Medicaid plan, and without any regard to any restrictions the State may impose on services for adults.

4) The health plan shall establish a tracking system that provides information on compliance with HCY/EPSDT service provision requirements in the following areas:

   - Initial visit for newborns. The initial HCY/EPSDT well child visits shall be the newborn physical exam in the hospital.

   - Preventive pediatric visits according to the periodicity schedule inclusive of a verbal lead assessment and blood lead tests.

   - Diagnosis and/or treatment, or other referrals in accordance with HCY/EPSDT well child visit results.

   - The health plan shall ensure that the tracking system generates information consistent with the requirements regarding encounter data as specified elsewhere herein.

5) The health plan shall have an established process for reminders, follow-ups, and outreach to members. This process shall include, but not be limited to, notifying the parent(s) or guardian(s) of children of the needs and scheduling of periodic well child visits according to the periodicity schedule. The health plan shall contact new members within thirty (30) calendar days of health plan enrollment to provide assistance in accessing HCY/EPSDT well child visit services. The health plan shall provide assistance to members in accessing subsequent HCY/EPSDT well child visits in accordance with the periodicity schedule. At the time of notification, the health plan shall offer transportation and scheduling assistance if necessary. For members with ME Codes 73 through 75, non-emergency medical transportation is not a covered benefit.

6) The health plan shall provide written notification to its families with eligible children when appropriate well child visits are due. The health plan shall follow-up with families that have failed to access well child visits after one hundred and twenty (120) calendar days of when the well child visit was due. The health plan shall provide to each PCP, on a monthly basis, a list of the eligible children who are not in compliance with the periodicity schedule.

7) For those children who have not had well child visits in accordance with the periodicity schedule established by the state agency, the health plan shall document its outreach and educational efforts to the parent or guardian informing them of: the importance of well child visits; that a well child visit is due; how and where to access services including necessary transportation (except to those children with ME Codes 73 through 75) and scheduling services; and a statement that service are provided without cost.

8) The health plan shall seek innovative, cooperative ways to enhance care coordination and delivery of HCY/EPSDT. This may include the use of a standardized data base system among health plans.

9) The health plan shall report HCY/EPSDT well child visits through encounter data submissions in accordance with the requirements regarding encounter data as specified elsewhere herein. The state agency shall use such encounter data submissions and other data sources to determine health plan compliance with CMS requirements that eighty percent (80%) of eligible members under the age of twenty-one (21) are receiving HCY/EPSDT well child visits in accordance with the periodicity schedule. The state agency shall use the participant ratio as calculated using the CMS 416 methodology for measuring the health plan's performance.

   - The health plan shall report HCY/EPSDT well child visits in accordance with the appropriate well child visits codes established by the state agency. HCY/EPSDT screening codes are identified in the state agency's *MO HealthNet Managed Care Policy Statements* located on the MO HealthNet website at Bidder and Vendor Documents

(http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/). Services not reported as HCY/EPSDT well child visits in accordance with the appropriate codes will not be counted toward the health plan's participant ratio.

- In the event the state agency uses other data sources submitted by the health plan, the health plan shall certify the data provided. The data must be certified by one of the following:
  - The health plan's Chief Executive Officer;
  - The health plan's Chief Financial Officer; or
  - An individual who has delegated authority to sign for, and who reports directly to, the health plan's Chief Executive Officer or Chief Financial Officer.
- The certification must attest, based on best knowledge, information, and belief, as to the accuracy, completeness, and truthfulness of the data.
- The health plan shall submit the certification concurrently with the data.

10) The health plan shall submit its HCY/EPSDT policies and procedures to the state agency for review and approval.

f. Emergency Medical, Behavioral Health, and Substance Abuse Services, and Post-stabilization Care Services:

1) Emergency medical, behavioral health, or substance abuse services means covered inpatient and outpatient services that are (1) furnished by a provider qualified to furnish these services and (2) needed to evaluate or stabilize an emergency medical condition. An emergency medical condition means a medical, behavioral health, or substance use-related condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious harm to self or others due to an alcohol or drug abuse emergency;
- Injury to self or bodily harm to others; or
- With respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn.

2) The health plan shall not limit what constitutes an emergency medical condition as defined herein on the basis of lists of diagnoses or symptoms.

3) Post-stabilization care services means covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized conditions or to improve or resolve the member's condition.

g. Family Planning Services: The health plan shall be financially liable for payment to providers, whether in-network or out-of-network, in accordance with Federal freedom of choice provisions.

h. Home Health Services;

i. Hospice Services: Hospice services for children (ages 0-20) may be concurrent with the care related to curative treatment of the condition for which a diagnosis of a terminal illness has been made.

j. Inpatient Hospital Services;

k. k. Laboratory, Radiology, and Other Diagnostic Services;

l. Local Public Health Agencies Services: The health plan is responsible for the following services provided by in-network providers and at local public health agencies whether in-network or out-of-network:

1) Sexually Transmitted Disease Services: All sexually transmitted disease (STD) services including screening, diagnosis, and treatment. In-network providers shall follow current Centers for Disease Control and Prevention (CDC) Sexually Transmitted Diseases Treatment Guidelines. The STD guidelines may be found on the Internet at: http://cdc.gov/std/treatment/ STD screening, diagnosis, and treatment services shall include:

- STD screening exam.
- Screening, diagnosis, and treatment for the following STDs: gonorrhea, syphilis, chancroid, granuloma inguinale, lymphogranuloma venereum, genital herpes, genital warts, trichomoniasis, chlamydia (cervicitis), chlamydia (urethritis), hepatitis B, and others as may be designated by the state agency.
- Screening, diagnosis, and treatment of vaginal or urethral discharge including non-gonococcal urethritis and mucopurulent cervicitis.
- Evaluation and initiation of treatment of pelvic inflammatory disease (PID).
- Diagnosis and preventive treatment of members who are reported as contacts/sex partners of any person diagnosed with a STD. The member shall be given the option of seeing an in-network provider first.
- The local public health agency shall encourage members to follow-up with their primary care provider; however, if the member chooses follow-up care at the local public health agency for confidentiality reasons, the health plan shall reimburse the local public health agency for follow-up office visits (not to exceed three (3) visits per episode).

2) Human Immunodeficiency Virus (HIV) Services: Human immunodeficiency virus (HIV) services relating to screening and diagnostic studies. In-network providers shall use *The Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health–Care Settings*. The HIV guidelines may be found on the Internet at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm.

3) Tuberculosis Services: Tuberculosis services include screening, diagnosis, and treatment. In-network providers shall follow current American Thoracic Society/CDC/Infectious Diseases Society of America Guidelines: Treatment of Tuberculosis MMWR 2003; 52 (No. RR-11), including the use of Mantoux PPD skin test or FDA-approved Interferon Gamma Release Assays (IGRAs) to screen for Tuberculosis. The Tuberculosis guidelines may be found on the Internet at: http://cdc.gov/mmwr/preview/mmwrhtml/rr5211a1.htm.

- All members diagnosed with tuberculosis infection or tuberculosis disease shall be reported to the local public health agency.

- All members receiving treatment for tuberculosis disease shall be referred to the local public health agency's tuberculosis contact person for directly observed therapy (DOT). The health plan shall communicate with the local public health agency's tuberculosis contact person to obtain information regarding the member's health status. The health plan shall communicate this information to the in-network provider. The health plan shall be responsible for care coordination and medically necessary follow-up treatment.

- All laboratory tests for tuberculosis shall meet the standards established by the CDC and the Missouri Department of Health and Senior Services. Sensitivity tests shall be performed on all initial specimens positive for M. Tuberculosis. The Department of Health and Senior Services encourage all sputum specimens to be submitted to the Department of Health and Senior Services' Tuberculosis Reference Laboratory at the Missouri Rehabilitation Center. Positive cultures for M Tuberculosis isolated at private laboratories must be sent to the TB Reference Laboratory (Required by Missouri Rule 19 CSR 20-20.080).

4) Childhood Immunizations: The health plan shall ensure that in-network providers fully immunize their members according to the most recent immunization recommendations designated by the state agency. The state agency shall provide the health plan's Medical Director with copies of the most recent recommendations upon contract award, upon request, and when the recommendations change.

   - The health plan and its in-network providers shall enroll and obtain vaccines through the Missouri Department of Health and Senior Services Vaccines for Children (VFC) Program or any such vaccine supply program as designated by the state agency. Any time a member receives immunizations from a local public health agency, or at a Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) site, the health plan shall reimburse only the cost for administration at the current MO HealthNet program rates in effect at the time of the service, unless otherwise negotiated. Members with ME codes 73 through 75 are not eligible to receive vaccines through the VFC Program.

   - The health plan shall reimburse governmental public health agencies for the cost of both administration and vaccines not available through the VFC program or vaccine supply program as designated by the state agency when the vaccine is deemed medically necessary.

   - The health plan shall collaborate with the state agency and the Missouri Department of Health and Senior Services to determine the health plan's aggregate immunization level. The Missouri Department of Health and Senior Services, Immunization Program will offer consultation to the health plan to foster the exchange of immunization information, and to in-network providers for purposes of assessment, reminder/recall, and reporting.

5) Childhood lead poisoning prevention services shall include screening, diagnosis, treatment, and follow-up as indicated. In-network providers shall follow the CMS guidelines in effect for the specific time period and CDC guidelines: Screening Young Children for Lead Poisoning and Managing Elevated Blood Lead Levels Among Young Children. The Department of Health and Senior Services shall provide the health plan's Medical Director with copies of current protocols and guidelines upon contract award or at any time upon request. If there is a discrepancy between guidelines, the state agency requires use of the HCY/EPSDT Lead Risk Assessment Guide developed in accordance with CMS guidelines. The HCY/EPSDT Lead

Risk Assessment Guide may be used separately or in conjunction with the HCY Screening form.

m. Maternity Benefits for Inpatient Hospital and Certified Nurse Midwife:

1) The health plan shall provide coverage for a minimum of forty-eight (48) hours of inpatient hospital services following a vaginal delivery and a minimum of ninety-six (96) hours of inpatient hospital services following a cesarean section for a mother and her newly born child in a hospital or any other health care facility licensed to provide obstetrical care under the provision of Chapter 197, RSMo, as amended.

2) The health plan may authorize a shorter length of hospital stay for services related to maternity and newborn care if a shorter inpatient hospital stay meets with the approval of the attending physician after consulting with the mother and is in keeping with Federal and State law, as amended. The physician's approval to discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization, and is documented in the member's medical record.

3) The health plan shall provide coverage for post-discharge care to the mother and her newborn. The first post-discharge visit shall occur within twenty-four (24) to forty-eight (48) hours. Post-discharge care shall consist of a minimum of two visits at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. The location and schedule of the post-discharge visits shall be determined by the attending physician. Services provided by the registered professional nurse or physician shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests, and submission of a metabolic specimen satisfactory to the State laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care", or similar guidelines prepared by another nationally recognized medical organization. If the health plan intends to use another nationally recognized medical organization's guidelines, the state agency must approve prior to implementation of its use.

n. Optical services include one (1) comprehensive or one(1) limited eye examination every two (2) years for refractive error, services related to trauma or treatment of disease/medical condition (including eye prosthetics), and one (1) pair eyeglasses every two (2) years (during any twenty-four (24) month period of time);

o. Outpatient Hospital Services;

p. Personal Care Services;

q. Physician, Advanced Practice Nurse, and Certified Nurse Midwife Services:

1) The health plan shall provide certified nurse midwife services that are medically appropriate either in-network or out-of network at the health plan's expense.

2) If the member elects a home birth, the health plan shall notify the state agency so that the member can be disenrolled from MO HealthNet Managed Care and enrolled in the MO HealthNet Fee-For-Service program.

r. Podiatry services with the exception of trimming of nondystrophic nails, any number; debridement of nail(s) by any method(s), one (1) to five (5); debridement of nail(s) by any method(s), six (6) or more; excision of nail and nail matrix, partial or complete; and strapping of ankle and/or foot;

s. Transplant Related Services: The health plan shall permit and authorize and shall be financially responsible for any inpatient, outpatient, physician, and related support services including presurgery assessment/evaluation prior to the date of the actual bone marrow/stem cell or solid organ transplant surgery. The bone marrow/stem cell or solid organ transplant will be prior authorized by the state agency and must be performed at a state agency's approved transplant facility in accordance with the MO HealthNet member's freedom of choice. The health plan shall be responsible for pre-transplant and post-transplant follow-up care. To ensure continuity of care, the health plan shall permit and authorize follow-up services and the health plan shall be responsible for the reimbursement of such services. The primary care provider shall be allowed to refer a transplant patient to the performing transplant facility for follow-up transplant care. The health plan shall reimburse out-of-network providers of transplant support services no less than the current MO HealthNet program rates in effect at the time of the services.

t. Transportation Services:

1) The health plan shall provide emergency transportation (ground and air) for its members.

2) The health plan shall provide non-emergency medical transportation to members except for children in ME Codes 73 - 75 (Refer to Category of Aid 5 in Attachment 1, *MO HealthNet Managed Care and Related Eligibility Groups*, and located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/) and children in State custody with the following ME Codes 08, 52, 57, and 64 (Refer to Category of Aid 4 in Attachment 1, *MO HealthNet Managed Care and Related Eligibility Groups*, and located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/) on the MO HealthNet website at Bidder and Vendor (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/) who do not have the ability to provide their own transportation (such as their own vehicle, friends, or relatives) to and from services required herein as well as to and from MO HealthNet Fee For Service covered services not included in the comprehensive benefit package.

2.7.6 **Cancer Screenings**: In accordance with State law, the health plan shall notify all members on an annual basis, in writing, of cancer screenings covered by the health plan and provide the current American Cancer Society guidelines for all cancer screenings.

2.7.7 **Additional Services**: In addition to the services listed in the comprehensive benefit package herein, the health plan shall provide the following services to children under twenty-one (21) years of age and pregnant women with ME codes 18, 43, 44, 45, and 61.

a. Comprehensive Day Rehabilitation (for certain persons with disabling impairments as the result of a traumatic head injury);

b. Dental Services – All preventative, diagnostic, and treatment services as outlined in the Medicaid State Plan;

c. Diabetes self-management training for persons with gestational, Type I, or Type II diabetes;

d. Hearing aids and related services;

e. Optical services to include one (1) comprehensive or one (1) limited eye examination per year for refractive error, one (1) pair of eyeglasses per year, and, for children under age twenty-one (21), HCY/EPSDT optical screen and services;

f. Podiatry services;

g. Services that are included in the comprehensive benefit package, medically necessary, and identified in the IFSP or IEP (except for physical therapy, occupational therapy, speech therapy, hearing aid, personal care, private duty nursing, or psychology/counseling services); and

h. Therapy services (physical, occupational, and speech) that are not identified in an IEP or IFSP. This includes maintenance, developmental, and all other therapies.

2.7.8 **Services for Children in the Custody of the Jackson County, Missouri Children's Division**: Children in the custody of the Jackson County, Missouri Children's Division (CD) and residing in Cass, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Ray, or St. Clair counties receive additional medical care services.

a. In addition to the services outlined herein, the health plan shall provide the following services following the effective date of enrollment with the health plan. If the child is already enrolled with the health plan and enters custody, the health plan shall provide the following services from the time the child enters CD custody. The timeframes for these examinations begin with the time and date the child enters CD custody.

1) An initial physical examination is due the within twenty-four (24) hours of a child's placement in CD custody. (This initial physical examination shall be paid by the state agency on a fee-for-service basis and arranged by CD if the child is not enrolled in a health plan at the time of the initial physical examination.) In all cases, if a child is enrolled with the health plan, the health plan shall be responsible for payment of the initial physical examination. CD, the Medical Case Management Agency, and the health plan shall work together to establish a notification process so that the health plan receives notification of the enrollment of a covered child who is under the jurisdiction of the court in Jackson County in a timely manner.

2) Follow-up examinations recommended by the provider during the initial physical examination shall be done in a timely manner.

3) Within thirty (30) days of placement in CD custody, the child must undergo a full Healthy Children and Youth (HCY) screening.

4) Children in CD custody under age ten (10) must receive ongoing physical, developmental, and mental health screenings every six (6) months. If the provider does not recommend a full HCY screening at the six-month interval, the provider is requested to complete an interperiodic screening.

5) Children in CD custody age ten (10) years and older should have continued follow up care for any service or treatment needs identified in the initial HCY screening.

b. The health plan shall be responsible for determinations regarding medically necessary treatments, medically necessary appointments, and medically necessary services.

2.7.9 **Medically Necessary**: The health plan shall be responsible for providing covered services sufficient in amount, duration, and scope to reasonably achieve their purpose, and in accordance with accepted standards of practice in the medical community of the area in which the services are rendered. Services shall be furnished in the most appropriate setting. Services may be limited by medical necessity. A service shall be considered medically necessary if it (1) prevents, diagnoses, or treats a physical or

behavioral health condition or injury; (2) is necessary for the member to achieve age appropriate growth and development; (3) minimizes the progression of disability; or (4) is necessary for the member to attain, maintain, or regain functional capacity. A service shall not be considered reasonable and medically necessary if it can be omitted without adversely affecting the member's condition or the quality of medical care rendered.

a. In reference to medically necessary care, behavioral health services shall be provided in accordance with a process of behavioral health assessment that accurately determines the clinical condition of the member and the acceptable standards of practice for such clinical conditions. The process of behavioral health assessment shall include distinct criteria for children and adolescents.

b. The health plan shall provide medically necessary services to children from birth through age twenty (20), which are necessary to treat or ameliorate defects, physical or behavioral health, or conditions identified by an HCY/EPSDT screen. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

2.7.10 **Additional Health Benefits**: The health plan may offer additional health benefits not included in the comprehensive benefit package to their members. If the health plan offers additional health benefits, the health plan shall notify the state agency of these benefits prior to their offering through the established marketing process and receive approval. The contractor shall agree and understand that the additional health benefits identified in the contractor's awarded proposal shall be subject to the state agency's final review and approval. Contract award does not constitute the state agency's approval or acceptance of the additional health benefits proposed in the health plan's awarded proposal. Additional health benefits from prior contracts will not be exempted from such approval. The health plan shall notify the state agency no less than thirty (30) calendar days prior to discontinuing such benefits. The health plan shall not portray required health benefits or services as an additional health benefit.

2.8 Second Opinion: The health plan shall provide for a second opinion, at no cost to members, from qualified health care professionals. The health plan shall have and implement policies and procedures for rendering second opinions both in-network and out-of-network when requested by a member. These policies and procedures shall address whether there is a need for referral by the primary care provider or self-referral. Missouri Revised Statutes Section 208.152 states that certain elective surgical procedures require a second medical opinion be provided prior to the surgery. A third surgical opinion, provided by a third provider, shall be allowed if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation, and if the member desires the third opinion.

2.9 Release for Ethical Reasons:

2.9.1 As a condition to participating in its provider network, the health plan may not:

a. Require a provider to perform any treatment or procedure which is contrary to the provider's conscience, religious beliefs, or ethical principles or policies; or

b. Prohibit a provider from making a referral to another health care provider licensed to provide care appropriate to the member's medical condition.

2.9.2 The health plan shall have a process by which the provider may refer a member to another health care provider licensed to provide care appropriate to the member's medical condition, or withdraw from the case and the health plan shall assign the member to another provider licensed to provide care appropriate to the member's medical condition.

2.9.3 The health plan may object, on moral and religious grounds, to providing or reimbursing for a service for which it is otherwise required to provide or reimburse. If the health plan objects to providing or reimbursing for a service on moral or religious grounds, the health plan shall notify the state agency. Additionally, the health plan shall notify the state agency *whenever the health plan adopts the policy*

during the term of the contract. The health plan agrees that such an objection and subsequent release from providing, reimbursing for, or providing coverage of a counseling or referral service shall result in a reduction to the applicable capitation rates paid to the health plan to reflect such a release as outlined herein. The health plan shall also:

a. Provide information to potential members prior to enrollment regarding the health plan's release of provision of such service;

b. Notify its members thirty (30) calendar days prior to any change in its policy regarding coverage of a counseling or referral service; and

c. Notify its members of how and where to obtain the service.

2.10 Coordination With Services not Included in the Comprehensive Benefit Package: The health plan is not obligated to provide or pay for any services not included in the comprehensive benefit package. This section provides additional information about some of the services not in the comprehensive benefit package. The health plan is responsible for coordinating the provision of services in the comprehensive benefits package with services not included within the comprehensive benefit package.

2.10.1 **Abortion Services**: Abortion services subject to MO HealthNet program benefits and limitations shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program.

2.10.2 **Adult Day Care Waiver**

a. Home and community based waiver services for Adult Day Care (ADC) Services include but are not limited to assistance with activities of daily living, planned group activities, food services, client observation, skilled nursing services as specified in the plan of care, and transportation. Planned group activities include socialization, recreation and cultural activities that stimulate the individual and help the client maintain optimal functioning. The health plan must arrange or provide transportation to the adult day care facility at no cost to the member. Reimbursement will be made for up to 120 minutes per day of transportation that is related to transporting the member to and from the Adult Day Care setting. Meals provided as part of ADC shall not constitute a "full nutritional regimen" (three (3) meals per day).

b. The health plan shall be responsible for MO HealthNet Managed Care comprehensive benefit package services for ADC waiver clients enrolled in MO HealthNet Managed Care, unless specifically excluded. The health plan shall be responsible for care coordination of services included in the comprehensive benefit package and the ADC waiver. Information regarding the ADC waiver services may be located on the DHSS website at: http://health.mo.gov/seniors/adhc/.

2.10.3 **Comprehensive Substance Treatment Abuse and Rehabilitation (C-STAR) Services:**

a. Services provided by a C-STAR MO HealthNet provider shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program.

b. In order to ensure quality of care, the health plan and its behavioral health/substance abuse treatment providers shall maintain open and consistent dialogue with C-STAR providers. The health plan shall be responsible for care coordination of services included in the comprehensive benefit package and C-STAR services in accordance with the *Behavioral Health and Substance Abuse Fee-For-Service Coordination and the Substance Abuse Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care* policy statement in the *MO HealthNet Managed Care Policy Statements* located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/).

2.10.4 **Behavioral Health Services**:

a. Services provided by a Community Psychiatric Rehabilitation provider shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program.

b. Targeted case management services for behavioral health services shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program.

c. Tobacco cessation pharmacologic and behavioral intervention services shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet fee-for-service program.

2.10.5 **Behavioral Health Services for Category Of Aid (COA) 4 Children**: For children within the COA 4 group, the health plan shall not be financially responsible for the following medically necessary behavioral health and substance abuse services:

a. Inpatient Behavioral Health and Substance Abuse Services shall be any psychiatric stay in an acute care hospital, or in a private or State psychiatric hospital. Admissions must be in accordance with established guidelines of the Department of Social Services in conjunction with the Department of Mental Health. The Department of Social Services in conjunction with the Department of Mental Health will determine the appropriateness of inpatient placement, the appropriate facility, alternative placement, and psychiatric diversion. The state agency's Medical Review Agency must certify medically necessary inpatient days for behavioral health and substance abuse services (billable on an inpatient hospital claim form) beyond the days deemed medically necessary for physical health. The health plan shall ensure that the member's primary care provider and the child's caseworker coordinate services.

b. Outpatient Behavioral Health and Substance Abuse Services must be provided by a licensed psychiatrist, licensed psychologist, licensed clinical social worker, licensed master social worker, licensed counselor, provisional licensed professional counselor, licensed psychiatric advanced practice nurse, licensed home health psychiatric nurse, Missouri-certified substance abuse counselor, or State certified behavioral health or substance abuse program. Outpatient Behavioral Health and Substance Abuse Services are not provided in an inpatient setting. Examples of appropriate settings are outpatient facility, office, or clinic settings. These services will be provided subject to MO HealthNet program benefits and limitations. Services provided by general practitioners rather than one of the behavioral health specialists listed above are not considered Behavioral Health and/or Substance Abuse Services, and are not the responsibility of the MO HealthNet fee-for-service program.

c. Comprehensive Community Support Services: Comprehensive Community Support Services are provided to children in the custody of the Children's Division who are found to have behavioral conditions which require rehabilitative services at a residential treatment or specialized foster care level of care or who are being discharged from these two treatment levels, and who require comprehensive community support services in order to maintain the rehabilitation treatment outcome in a less restrictive environment. The Children's Division identifies children in the custody of the Children's Division qualifying for these services and authorizes provision of comprehensive community support. Comprehensive community support services include any medical or remedial service reasonable and necessary for maximum reduction of a behavioral disability and restoration of the child to his or her best possible functional level. Examples include, but are not limited to: Intake, Assessment, Evaluation and Treatment Planning; Community Support; Specialized Sexual Abuse Treatment: 24-hour Crisis Intervention and Stabilization; Intensive In-Home Services; Medication Management and Monitoring; Day Treatment/Psychosocial Rehabilitation; Therapeutic Counseling or Consultation Services not Covered Separately through the HCY or Physician's

Services Program; Supported Independent Living and Transitional Living Services; and School-Based Behavioral Support Services not included in the IEP. The services shall be provided subject to MO HealthNet program benefits and limitations.

2.10.6 **Developmental Disabilities (DD) Waiver Services**:

a. Home and community-based waiver services for persons in the DD waiver are carved out of the MO HealthNet Managed Care Program. There are five (5) waivers operated by the Department of Mental Health, Division of Developmental Disabilities. Four (4) of the waivers may include individuals in Managed Care. Home and community based waiver services vary from waiver to waiver and may include, but are not limited to: behavioral analysis services, personal assistant, in-home respite, job discovery, job preparation, out-of-home respite, environmental accessibility adaptations, dental, independent living skills, specialized medical equipment and supplies, physical therapy, occupational therapy, speech therapy, residential, support broker, and transportation. The state agency shall identify the DD waiver participants to the health plan.

b. The health plan shall be responsible for MO HealthNet Managed Care comprehensive benefit package services for DD waiver clients enrolled in MO HealthNet Managed Care, unless specifically excluded. The health plan shall be responsible for care coordination of services included in the comprehensive benefit package and the DD waivers. Information regarding DD waiver services may be found in Sections 13 and 19 of the MO HealthNet DD Waiver Provider Manual; MO HealthNet Provider Bulletins located on the internet at http://www.dss.mo.gov/mhd/providers/pages/bulletins.htm; and on the MO HealthNet Division website, Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/), in the *Waivers operated by the Department of Mental Health, Division of Developmental Disabilities which may include Managed Care Individuals.*

2.10.7 **Pharmacy Services**:

a. Pharmacy services (including physician injections) shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program.

b. The health plan shall coordinate with the state agency as necessary to ensure that members receive pharmacy services without interruption. In addition, the health plan shall provide information to members about appropriate prescription drug usage and shall monitor and manage providers' prescribing patterns through activities such as educating providers regarding practice patterns and intervening with providers whose practice patterns appear to be operating outside industry or peer norms.

c. The carve out of pharmacy services is defined to include all medications and pharmaceuticals administered on an outpatient basis, including physician-administered drugs, covered over-the-counter (OTC) products, all drugs dispensed by outpatient pharmacies, medications administered in the outpatient department of a hospital, or other outpatient clinics, according to the terms and conditions of the MO HealthNet Pharmacy Program. The MO HealthNet Pharmacy Program covers a select list of OTC products. The list of covered OTC products may be found on the internet at http://dss.mo.gov/mhd/cs/pharmacy/pdf/otc_coveredproducts.pdf. The MO HealthNet Pharmacy Program will cover diabetic medication (oral and injectable), syringes, and diabetic testing equipment and directly related supplies such as strips, calibration solution, lancets, and alcohol pads For pharmacy services provided in a home health setting, the MO HealthNet Pharmacy Program will cover the pharmacy service when billed on a pharmacy claim form including all of the appropriate information such as, but not limited to, the National Drug Code, quantity, and dosage form. The health plan shall be responsible for the home health visit and all supplies incidental to the administration of the medication. The MO HealthNet Pharmacy Program covers tobacco cessation, pharmacologic and behavioral intervention services for MO HealthNet Managed Care participant.

The carve out of pharmacy services does not include pharmacy services provided during or incident to an inpatient hospital stay or during or incident to an observational unit status.

d. CyberAccess[sm] is a web-based, HIPAA-compliant tool which provides all paid pharmacy claims data submitted for the members over the most recent thirty-six (36) contiguous months (including, but not limited to, submitted managed care encounter medical, inpatient and outpatient hospital, and dental claims data). In addition to member health information, CyberAccess[sm] provides the health plans access to the clinical rules engine used to jury prior authorization or clinical edit criteria for prescription drugs. A Medicaid Possession Ratio (MPR) calculation for maintenance medications is displayed in the tool which notifies prescribers and the health plan of a member's adherence to prescribed medications. CyberAccess[sm] will allow the health plan to view drug utilization information in near real time, and pharmacy claims data extracts will be available for the health plan to integrate into its existing decision support tools to promote medical management.

2.10.8 **Public Health Programs**: Services offered by the Department of Health and Senior Services and local public health agencies and the method of reimbursement shall include:

a. Environmental Lead Assessments for health plan children with elevated blood levels shall be reimbursed directly by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program.

b. State Public Health Laboratory Services to Members: In cases where the health plan is required by law to use the State Public Health Laboratories (e.g., metabolic testing for newborns) and in cases where the State Public Health Laboratory and Department of Health and Senior Services designated local public health agency laboratories perform tests, other than those services listed herein, on members for public health purposes, the laboratory shall be reimbursed directly by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program. Such costs shall not be included in the Medicaid State plan capitated rates.

c. Newborn Screening Collection Kits: According to RSMo 191.331, health care providers must purchase pre-paid newborn screening collection kits from the Department of Health and Senior Services. The Department of Health and Senior Services sells the kit to providers. When the provider submits a specimen to the State Department of Health and Senior Services Laboratory, the laboratory shall process the test, determine if the member is MO HealthNet eligible, and bill the state agency for the test.

d. Special Supplemental Nutrition for Women, Infants and Children (WIC) Program

- Sections 1902(a)(11)(C) and 1902(a)(53) of the Act and Title 42, CFR 431.635 require coordination between the state agency and the WIC program. Title 7 CFR 246.7 states that members of a family in which a pregnant woman or an infant is certified eligible to receive assistance under Medicaid are automatically income eligible for the WIC program. The health plan shall be familiar with the WIC eligibility criteria found on the Department of Health and Senior Services WIC web page at: http://health.mo.gov/living/families/wic/wiclwp/eligibilitylwp.php.

- The health plan shall require its in-network providers to document and refer eligible members for WIC services. As part of the initial assessment of members, and as a part of the initial evaluation of newly pregnant women, the in-network providers shall provide and document the referral of pregnant, breast-feeding, or postpartum women, or a parent/guardian of a child under the age of five, as indicated, to the WIC Program. (Local WIC provider locations, contact information, and hours of operations can be found on the Department of Health and Senior Services WIC web page at: http://health.mo.gov/living/families/wic/.)

2.10.9 **SAFE-CARE Exams**: Sexual Assault Forensic Examination and Child Abuse Resource Education (SAFE-CARE) examinations and related diagnostic studies which ascertain the likelihood of sexual or physical abuse performed by SAFE-CARE trained providers shall continue to be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program. The state agency shall define which services will continue to be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program when performed or requested by a SAFE-CARE trained provider. Other medically necessary services may be ordered by the SAFE-CARE provider by referring to an in-network provider when possible. The health plan shall be responsible for these services, regardless of whether the SAFE-CARE provider is in or out of the health plan network.

2.10.10 **Services in a Public School Setting**:

a. School Based Direct Services:

1) The health plan shall not be financially liable for physical therapy (PT), occupational therapy (OT), speech therapy (ST), hearing aid, personal care, private duty nursing, or psychology/counseling services included in an IEP developed by the public school. IEPs will include services which are needed due to developmental and educational needs. The health plan shall be financially liable and shall not delay the provision of school based direct services that are medically necessary pending completion of the IEP.

2) The health plan shall coordinate the provision of school based clinic services with comprehensive benefit services that are the responsibility of the health plan. In addition, the health plan shall have a written process for coordination and collaboration with school based clinics, for promptly transferring medical and developmental data, and for coordinating ongoing care with special education services.

b. First Steps:

1) The health plan shall not be financially liable for services included in an IFSP developed under the First Steps Program. IFSPs include services which are needed due to developmental and educational needs.

2) First Steps is an early intervention program required by the Individuals with Disabilities Education Act (IDEA) - Part C (34 CFR 303) Early Intervention Program for Infants and Toddlers with Disabilities) which also defines the IFSP. The First Steps program serves children from birth to age three (3) who have a fifty percent (50%) or greater delay in development or a diagnosed medical condition known to cause developmental delay. Enrollment in the First Steps program is voluntary at the choice of the child's parent or guardian. The intent of the program is, through early identification and intervention, to improve functioning in order to better prepare the child to participate in school. The Missouri Department of Elementary and Secondary Education (DESE) operates the First Steps program. Service Coordinators, employed by the System Point of Entry (SPOE) agency that contracts with DESE, are responsible for determining program eligibility based on multi-disciplinary evaluation of the child. The IFSP team determines the child's service needs. With the parent/guardian consent, the health plan shall refer children who are potentially eligible for First Steps services to the local First Steps office (System Point of Entry) or call the state-wide toll-free number, 866-583-2392, to make a referral.

3) The health plan shall coordinate the provision of First Steps services with comprehensive benefit services that are the responsibility of the health plan. In addition, the health plan shall have a written process for coordination and collaboration with First Steps, for promptly transferring medical and developmental data, and for coordinating ongoing care with special

education services. The health plan shall not delay the provision of therapies that are medically necessary pending completion of the IFSP.

c. Parents as Teachers (PAT):

1) PAT is a home-school-community partnership which supports parents in their role as their child's first and most influential teachers. Every family who is expecting a child or has a child under the age of kindergarten entry is eligible for PAT. PAT services include personal visits from certified parent educators, group meetings, developmental screenings, and connections with other community resources. PAT programs collaborate with other agencies and programs to meet families' needs, including Head Start, First Steps, the Women Infants and Children Program (nutrition services), local health departments, FSD, etc. Independent evaluations of PAT show that children served by this program are significantly more advanced in language development, problem solving, and social development at age three (3) than comparison children, ninety-nine point five percent (99.5%) of participating families are free of abuse or neglect, and early gains are maintained in elementary school, based on standardized tests. The PAT program is administered at the local level by the public school districts in the State of Missouri. Families interested in PAT may contact their local district directly. PAT also accepts referrals from other sources including medical providers. (Additional information about PAT is available at the Department of Elementary and Secondary Education's website at http://www.dese.mo.gov/. To navigate to the web page, follow the links: A-Z Index, "E," "Early Childhood Education," and then "Parents as Teachers.")

2) PAT is not a Medicaid covered service. The health plan shall encourage in-network pediatric providers to make referrals to the PAT program.

2.10.11 **Services for Children in the Custody of the Jackson County Office of the Missouri Children's Division**: Children in the custody of the Jackson County Office of the Missouri Children's Division (CD) and residing in Cass, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Ray, or St. Clair counties receive additional medical care services.

a. The health plan is not responsible for targeted medical case management services. Medical case management services are intended to facilitate access to medical services for the targeted children. Per the contract with Medical Case Management agencies, children are followed at three different levels: Category 1, well children; Category 2, children with behavioral health needs; and Category 3, children with medical needs. Children identified as Category 2 and Category 3 will remain in targeted medical case management during the entire time they are in custody. Category 1 children will be enrolled for targeted medical case management only during the first thirty (30) calendar days of custody. The medical case management services provided by the Medical Case Management Agency include, but are not limited to:

1) Promoting the effective and efficient access to comprehensive medical services for the targeted children;

2) Facilitating the coordination of medical services;

3) Maintaining confidential centralized files for each child;

4) Assisting in the education of CD staff, caregivers, and health care providers regarding the child's medical care;

5) Providing information regarding the need for specialized health services; and

6) Coordinating and monitoring all primary and specialty care necessary for the child.

b. The health plan and its providers shall cooperate with the Medical Case Management Agency in securing medical histories and providing medical records. The health plan shall allow case managers to file an appeal immediately (or within twelve (12) hours if a concern arises after regular business hours) to the health plan's Medical Director if a case managed child is denied services or has difficulty accessing services covered in the contract.

c. The health plan shall designate a person within the health plan as a primary contact for CD staff, caregivers, and health care providers for issues involving these targeted children. The health plan shall also participate and attend medical oversight meetings.

2.10.12 Transplant Services: The health plan shall coordinate services for a member requiring a transplant. Solid organ and bone marrow/stem cell transplant services will be paid for all populations on a fee-for-service basis outside of the comprehensive benefit package. Transplant services covered by fee-for-service are defined as the hospitalization from the date of transplant procedure until the date of discharge, including solid organ or bone marrow/stem cell procurement charges, and related physician services associated with both procurement and the transplant procedure. The health plan shall not be responsible for the covered transplant but shall coordinate the pre- and post-transplant services. Please reference *MO HealthNet Managed Care Policy Statements* located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/).

a. The health plan shall be responsible for any services before and after this admission, including the evaluation that may be related to the condition, even though these services may be delivered out-of-network. The state agency will inform the health plan of the approved covered transplant in order for the health plan to coordinate services.

b. The health plan shall not be financially responsible for immuno-suppressive pharmacological products prescribed after the inpatient transplant discharge.

c. According to 42 CFR 431.51, Medicaid must ensure freedom of choice of providers for services provided to Medicaid beneficiaries when those services are paid on a fee-for-service basis outside the health plan. When in-network providers identify a member as a potential transplant candidate, the member must be referred to a transplant facility of their choice without regard to health plan preference.

2.11 Case Management and Disease Management:

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

2.11.1 **Case Management**: The health plan shall provide case management to selected members. The health plan case management service shall focus on enhancing and coordinating a member's care across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by members/families with complex issues; ensuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual members; addressing and resolving patterns of issues that have negative quality, health, and cost impact; and creating opportunities and systems to enhance outcomes. The health plan may use a Section 2703 designated health home providers to perform case management functions if the health home practice is a member of the health plan network. In this event, the health plan shall have processes in place to monitor service delivery. The state agency will evaluate the health plan's case management and disease management programs during the readiness review and annually throughout the term of the contract. The tool for review of the health plan's case management and disease management programs will be provided upon contract award. The tool is subject to review and modifications by the state agency at the state agency's discretion

a. Case management record documentation must include, but not be limited to, the following:

1) Referrals;

2) Assessment/Reassessment;

3) Medical History;

4) Psychiatric History;

5) Developmental History;

6) Medical Conditions;

7) Care Planning;

8) Provider Treatment Plans;

9) Testing;

10) Progress/Contact Notes;

11) Discharge Plans;

12) Aftercare;

13) Transfers;

14) Coordination/Linking of Services;

15) Monitoring of Services and Care; and

16) Follow-up.

b. General Overview:

1) The health plan shall conduct case management services in order to achieve the following outcomes:

- Improved patient care;
- Improved health outcomes;
- Reduction of inappropriate inpatient hospitalization;
- Reduction of inappropriate utilization of emergent services;
- Lower total costs; and
- Better educated providers and members.

2) The health plan shall inform members selected for case management of the following:

- The nature of the case management relationship;
- Circumstances under which information will be disclosed to third parties;
- The availability of a complaint process; and

- The rationale for implementing case management services.

3) The case managers shall verify that the information listed herein has been provided to the member and record the verification in the member's care plan.

4) The health plan shall notify members via the member handbook that they may request case management services at any time.

5) The health plan shall have policies and procedures for case management. The policies and procedures shall include:

- A description of the system for identifying and screening members for case management services;
- Provider and member profiling activities;
- Procedures for conducting provider education on case management;
- A description of how claims analysis will be used;
- A process to ensure that the primary care provider, member parent/guardian, and any specialists caring for the member are involved in the development of the care plan;
- A process to ensure integration and communication between physical and behavioral health;
- A description of the protocols for communication and responsibility sharing in cases where more than one case manager is assigned;
- A process to ensure that care plans are maintained and up-dated as necessary;
- A description of the methodology for assigning and monitoring case management caseloads that ensures adequate staffing to meet case management requirements;
- Timeframes for reevaluation and criteria for case management closure; and
- Adherence to any applicable State quality assurance, certification review standards, and practice guidelines as described in herein.

c. General Eligibility and Assessment:

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

1) The health plan shall screen all pregnant members for case/care management needs and offer case management to all pregnant members. The health plan shall offer case management within fifteen (15) business days of notification of pregnancy. The initial case management and admission encounter shall include an assessment (face-to-face or phone) of the member's needs.

2) The health plan shall offer case management within the following timeframes to all children when knowledge of elevated blood lead levels is present:

- 10 to 19 ug/dL within 1–3 business days
- 20 to 44 ug/dL within 1–2 business days
- 45 to 69 ug/dL within 24 hours
- 70 ug/dL or greater - immediately

3) The health plan shall perform an assessment for case management within thirty (30) calendar days of enrollment for new members who present with a diagnosis listed below and who are not enrolled in the State health home program. The health plan shall perform an assessment for case management within thirty (30) calendar days of diagnosis for existing members who receive a new diagnosis listed below and who are not enrolled in the State health home program:

- Diabetes;
- Asthma;
- COPD;
- Congestive heart failure;
- Cancer;
- Chronic pain with opioid dependence;
- Hepatitis C in active treatment;
- HIV/AIDS
- Organ failure requiring supportive treatment and potentially requiring transplant (e.g., ESRD and dialysis requirement or pancreatic/hepatic failure);
- Individuals with special health care needs including those with Autism Spectrum Disorder. Individuals with special health care needs are those individuals that without services such as private duty nursing, home health, durable medical equipment/supplies, and case management may require hospitalization or institutionalization. The following groups of individuals are at high risk of having a special health care need:

  - Individuals with Autism Spectrum Disorder;

  - Individuals eligible for Supplemental Security Income (SSI);

  - Individuals in foster care, receiving foster care or an adoption subsidy or other out-of-home placement; and

  - Individuals receiving services through a family-centered community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as defined by the state agency in terms of either program participant or special health care needs.

- Sickle Cell Anemia; and
- Serious mental illness (schizophrenia, bipolar disorder, PTSD, recurrent major depression, and substance dependence disorder with alcohol and IV drug use).

4) The health plan shall provide an assessment for case management for all members experiencing one (1) of the events listed below. The health plan shall conduct such assessments within thirty (30) calendar days of:

- The date upon which a member receives the projected discharge date from hospitalization or rehabilitation facilities:

  - After re-admission; or
  - After a stay of more than two (2) weeks.

- The last day of the month following the end of a quarter in which a member has had three (3) or more emergency department visits as identified through analysis of utilization data;

5) The health plan shall assess members for case management within five (5) business days of admission to a psychiatric hospital or residential substance abuse treatment program.

6) The health plan shall use the enrollment broker health risk assessment screening information to determine which new members require screening and potential enrollment in case management at the time of enrollment.

d. Care Plans:

1) For all eligible members, the health plan shall use the initial assessment to identify the issues necessary to formulate the care plan. All care plans shall have the following components:

- Use of clinical practice guidelines (including the use of CyberAccess[sm] to monitor and improve medication adherence and prescribing practices consistent with practice guidelines);
- Use of transportation, community resources, and natural supports (e.g. friends, family, neighbors, acquaintances, co-workers, volunteers, peers, church members);
- Specialized physician and other practitioner care targeted to meet member's needs;
- Member education on accessing services and assistance in making informed decisions about care;
- Prioritized based on the assessment of the member's needs that are measurable and achievable;
- Emphasis on prevention, continuity of care, and coordination of care. The system shall advocate for and link members to services as necessary across providers and settings; and
- Reviews to promote achievement of case management goals and use of the information for quality management.

2) In addition to the requirements listed above, the health plan shall include the following in the care plans of pregnant women:

- A risk appraisal form must be a part of the member's record. The health plan may use the state agency form or any form that contains, at a minimum, the information required in the MHD Risk Appraisal form. These forms may be obtained from the Physician Provider manual on the state agency's website: www.dss.mo.gov/mhd.
- Intermediate referrals to substance-related treatment services if the member is identified as being a substance user. If the member is referred to a C-STAR program, care coordination should occur in accordance with the Substance Abuse Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care.
- Referrals to prenatal care (if not already enrolled), within two (2) weeks of enrollment in case management;
- Tracking mechanism for all prenatal and post-partum medical appointments. Follow-up on broken appointments shall be made within one (1) week of the appointment;
- Methods to ensure that EPSDT/HCY screens are current if the member is under age twenty-one (21);

- Referrals to WIC (if not already enrolled), within two (2) weeks of enrollment in case management;
- Assistance in making delivery arrangements by the twenty-fourth (24th) week of gestation;
- Assistance in making transportation arrangements for prenatal care, delivery, and post-partum care;
- Referrals to prenatal or childbirth education where available;
- Assistance in planning for alternative living arrangements which are accessible within twenty-four (24) hours for those who are subject to abuse or abandonment;
- Assistance to the mother in enrolling the newborn in ongoing primary care (EPSDT/HCY services) including provision of referral/assistance with MO HealthNet application for the child, if needed;
- Assistance in identifying and selecting a medical care provider for both the mother and the child;
- Identification of feeding method for the child;
- Notifications to current health care providers when case management services are discontinued;
- Referrals for family planning services if requested; and
- Directions to start taking folic acid vitamin before the next pregnancy.

3) If the health plan wants to use local public health agencies to provide services, the health plan shall enter into written contracts with the local public health agencies. However, the health plan is not required to contract with outside entities for prenatal case management services.

4) In addition to the requirements listed above, the health plan shall:

- Include the following services in the care plans for children with elevated blood lead levels:
  - ➢ Ensure confirmation of capillary tests using venous blood according to the timeframe listed below:
    - ✓ 10-19µg/dL – Within two (2) months.
    - ✓ 20-44µg/dL – Within two (2) weeks.
    - ✓ 45-69µg/dL – Within two (2) days.
    - ✓ 70 µg/dL – Immediately.
  - ➢ Ensure that the Childhood Blood Lead Testing and Follow Up Guidelines are followed as required:
    - ✓ 10-19µg/dL – 2-3 month intervals.
    - ✓ 20-70+µg/dL – 1-2 months intervals, or depending upon the degree of the elevated lead level, by physician discretion until the following three conditions are met:
      - ▪ BLL remains less than 15µg/dL for at least 6 months;

- Lead hazards have been removed; and
- There are no new exposures.

When the above conditions have been met, proceed with retest intervals and follow-up for BLLs 10-19µg/dL.

- A minimum of three (3) member/family encounters, all face-to-face. Initial visit must be performed within two (2) weeks of receiving a confirmatory blood lead level that met the lead case management requirements. This visit must include the following:

  - ✓ A member/family assessment;
  - ✓ Provision of lead poisoning education offered by health care providers;
  - ✓ Engagement of member/family in the development of the care plan; and
  - ✓ Delivery of the case manager's name and telephone number.

- Follow-up visit or second (2nd) encounter within three (3) months following the initial encounter. Assessment and review of the child's progress, parental compliance with recommended interventions, reinforcement of lead poisoning education, member education, and the medical regime should be performed at that time.

- An exit evaluation or third (3rd) encounter is required to be performed prior to discharge between the sixth (6th) to seventh (7th) month after the initial encounter unless there is a medically necessary need for further follow-up. If the child meets the criteria for discharge, this encounter must include, but not limited to, discharge counseling regarding current blood lead level status, review of ongoing techniques for prevention of re-exposure to lead hazards, as well as nutrition, hygiene, and environmental maintenance.

- Document the following in the member record:

  - Initial visit: The admission progress note must document contact with child's PCP and any planned interventions by the health plan or subcontractor case manager. The notes must also include the plan of care and include, at a minimum, blood lead level/s, assessment of the member/family including resulting recommendations, and lead poisoning education that includes acknowledgement of parental understanding of this education.

  - The health plan shall use the web-based Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC) Lead Application to document lead case management activities. The health plan may use the DHSS Childhood Lead Poisoning Prevention Program Nurse's Lead Case Management Questionnaire and the Nutritional Assessment forms to assist them in capturing all the required case management elements for documentation. Both forms are found in the Lead Poisoning Prevention Manual at http://health.mo.gov.

  - Follow-up visit(s): The documentation must include the most recent laboratory results, member status, any interventions by case manager, contacts with the child's primary care provider and progress made to meet plan of care goals.

  - Exit visit: The discharge documentation must include the date of discharge, reason for discharge, lab results, member status, and exit counseling. The exit counseling documentation must include a telephone number for member questions and assistance, and status of plan of care goal completion. The documentation must include member/family and primary care provider notification of discharge from case management and continued care coordination plan.

e. Case Management Closure:

1) The health plan shall have criteria for terminating case management services. These criteria shall be included in the care plans. Acceptable reasons for case closure for case management (excluding case management for elevated lead levels) include:

- Achievement of goals stated in care plan including stabilization of the member's condition, successful links to community support and education, and improved member health;
- Member request to withdraw from either case management or the health plan; and
- Lack of contact with the case manager or compliance with case management must be documented in the care plan. At least three (3) different types of attempts to locate and engage the member should be made to contact the family prior to closure for this reason. Examples of contact attempts include:
  - Making phone call attempts before, during, and after regular working hours;
  - Visiting the family's home;
  - Sending letters with an address correction request; and
  - Checking with primary care provider, Women, Infants, and Children (WIC), and other providers and programs.
- The health plan shall review cases for closure from prenatal case management no sooner than sixty (60) days from the date of delivery.
- For children receiving case management due to elevated blood lead levels, the health plan shall review cases for closure using the following occurrences:
  - When current blood lead level is less than 10 ug/dL; or
  - When the child is disenrolled and referral to a new health plan, local public health agency, or health care provider has been completed.
- The PCP must be notified in writing of all instances of children discharged from case management and the reason for discharge. The discharge notification must include a history of the child's condition.
- The health plan shall provide quarterly and yearly outcome measurement and reporting. The reporting requirements specified herein will satisfy this component.

2.11.2 **Disease Management (DM)**: Disease management is the process of intensively managing a particular disease or syndrome. Disease management encompasses all settings of care and places a heavy emphasis on prevention and maintenance. It is similar to case management, but more focused on a defined set of programs relative to an illness or syndrome. (Definition used with permission of Center for Health Care Strategies, Inc., Princeton, New Jersey, "Case Management in Managed Care for People with Developmental Disabilities: Models, Costs and Outcomes, January, 1999".)

a. The health plan shall have disease management programs for major depression, asthma, and at least one of the following: obesity, diabetes, hypertension, or Attention Deficit Hyperactivity Disorder (ADHD). The health plan may use a Section 2703 designated health home providers to perform disease management functions if the health home practice is a member of the health plan network.

In the event of such, the health plan shall have processes in place to monitor service delivery and ensure that all requirements, as described herein, are adequately performed.

b. The DM programs shall:

1) Have systematic methods of identifying and enrolling members in each program. As such, the health plan shall utilize the information gathered upon initial enrollment into the health plan and the MO HealthNet program and use of clinical diagnosis codes. In addition, the health plan shall offer disease management to members as early in the development of the disease state as possible. The health plan shall operate its disease management programs using an "opt out" methodology, meaning that disease management services shall be provided to eligible members unless they specifically ask to be excluded.

2) Utilize evidence-based clinical practice guidelines (hereafter referred to as the guidelines) that have been formally adopted by the health plan's Quality Management/Quality Improvement (QM/QI) committee or other clinical committee and member empowerment strategies to support the provider-member relationship and the plan of care.

3) Emphasize the prevention of exacerbation and complications of the conditions as evidenced by decreases in emergency room utilization and inpatient hospitalization and/or improvements in condition-specific health status indicators.

4) Classify eligible members into stratification levels according to condition severity or other clinical or member-provided information. The DM programs shall tailor the program content, education activities, and benchmarks and goals for each risk level.

5) Take a member-centered approach to providing care by addressing psychological aspects, caregiver issues, and treatment of disease using nationally recognized standards of care.

6) Incorporate culturally appropriate interventions including, but not limited to, taking into account the multi-lingual, multi-cultural nature of the member population.

7) Have program content that includes the development of treatment plans that serve as the outline for all of the activities and interventions in the program. At a minimum, the activities and interventions associated with the treatment plan shall address condition monitoring, member adherence to the treatment plan, consideration of other co-morbidities, and condition-related lifestyle issues. The member shall participate in the development of the treatment plan if desired.

8) Have methods for informing and educating members and/or their caregivers regarding their particular condition(s) and needs. This information shall be provided upon enrollment in the DM program. The DM programs shall educate members to increase their understanding of their condition(s), the factors that impact their health status (e.g., diet and nutrition, lifestyle, exercise, medication compliance), and to empower members to be more effective in self-care and management of their health so they:

- Are proactive and effective partners in their care;
- Understand the appropriate use of resources needed for their care;
- Identify precipitating factors and appropriate responses before they require more acute intervention; and
- Are compliant and cooperative with the recommended treatment plan.

9) Have methods for informing and educating providers regarding the clinical practice guidelines. The health plan shall distribute the guidelines to providers who are likely to treat members with the DM conditions. This includes, but is not limited to, PCPs and specialists involved in treating that particular condition. The health plan shall also provide each PCP with a list of their members enrolled in each DM program upon the member's initial enrollment and at least annually thereafter. The health plan shall provide specific information to the provider concerning how the program(s) works. The DM's provider education shall be designed to increase the providers' adherence to the guidelines in order to improve the members' conditions.

10) Have established measurable benchmarks and goals for each DM program that are used to evaluate the programs. These benchmarks and goals shall be specific to each condition and should include:

- Performance measured against at least two important clinical aspects of the guidelines associated with each DM program;
- The rate of emergency department utilization and inpatient hospitalization for asthma;
- Appropriate HEDIS measures;
- The passive participation rates (as defined by the National Committee for Quality Assurance (NCQA) and the number of individuals participating in each level of each of the DM programs;
- Cost savings;
- Member adherence to treatment plans; and
- Provider adherence to the clinical practice guidelines.

c. The health plan shall develop and maintain DM program policies and procedures that describe how the programs will incorporate all components listed above. These policies and procedures shall address how the DM programs will coordinate with case management activities, in particular for members who would benefit from both.

d. The health plan shall submit the disease management program reports as required herein.

2.12 Eligibility, Enrollment, and Disenrollment:

2.12.1 The Missouri Department of Social Services, the Family Support Division (FSD) is responsible for eligibility determinations. The state agency will conduct enrollment activities for MO HealthNet Managed Care eligibles. The health plan or its subcontractors may assist enrollees with applying for MO HealthNet benefits including assisting mothers of newborns with supplying information to the FSD. The health plan or its subcontractors shall not conduct or participate in eligibility or enrollment activities.

2.12.2 **Enrollment Counseling**: The state agency will operate a toll-free telephone line to make helpline operators available to all MO HealthNet Managed Care eligibles to provide assistance in selecting and enrolling into a health plan. Helpline operators also will be available by telephone to assist MO HealthNet Managed Care eligibles who would like to change health plans. The health plan shall refer MO HealthNet Managed Care eligibles and members to the toll-free helpline when needed. The helpline operator responsibilities will include the following:

a. Educating the eligible and family about Managed Care in general, including the requirement to enroll in a health plan, the way services typically are accessed under Managed Care, the role of the primary

care provider, the health plan member's right to choose a primary care provider subject to the capacity of the provider, the responsibilities of the health plan member, and the member's rights including the right to file grievances and appeals and to request a State fair hearing.

b. Educating the eligible and family about benefits available through the health plan, both in-network and out-of-network.

c. Informing the eligible and family of available health plans and outlining criteria that might be important when making a choice (e.g., presence or absence of existing provider(s) in the health plan provider network).

d. Identifying any sources of Third Party Liability that were not identified by the FSD eligibility specialist.

e. Administering a health plan screen as designated by the state agency that collects baseline health status data to be used as part of the health plan program evaluation and initial determination for case management, disease management, LCCC, and health home programs. Any baseline health status data shall be made available to the health plan. *The Department of Social Services MO HealthNet Managed Care Health Risk Assessment* template is located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/).

f. Inquiring and recording primary language information.

g. Explaining options for obtaining services outside the health plan network.

h. Providing a listing of the health plan primary care providers generated from the provider demographic electronic file submitted by the health plan to the state agency.

2.12.3 **Voluntary Selection of Health Plan**: MO HealthNet Managed Care eligibles will be given fifteen (15) calendar days from the date the FSD determines them eligible for Managed Care to select a health plan. All members of a family shall be encouraged to select the same health plan. If a family does not select a health plan within the fifteen (15) calendar day window, the state agency will automatically assign the family to a health plan.

2.12.4 **Automatic Assignment Into Health Plans**: Following the open enrollment period, the state agency will employ an algorithm to assign members to each health plan, on a prorated basis. For any MO HealthNet Managed Care eligibles who do not make a voluntary selection of a health plan during open enrollment, the algorithm shall be based on the following:

a. If the MO HealthNet Managed Care eligible's case head is enrolled with a health plan, the MO HealthNet Managed Care eligible shall be assigned to that health plan. If not, the next step in the algorithm will be followed.

b. If the MO HealthNet Managed Care eligible is included in a MO HealthNet eligibility case where another member is enrolled with a health plan, the MO HealthNet Managed Care eligible shall be assigned to that health plan. If not, the MO HealthNet Managed Care eligible will be assigned randomly as outlined in the remainder of the section.

c. If a health plan has sixty percent (60%) of the regional membership or greater, regional auto-assignment into the health plan will be limited to individuals meeting the algorithm criteria for only items (a) and (b) above.

d. If one health plan has less than twenty percent (20%) of the regional membership, that health plan will receive one hundred percent (100%) of the auto-assigned membership following the application of the algorithm criteria for items (a) and (b) above.

e. If multiple health plans have enrollment below twenty percent (20%) of the regional membership, 100% of the auto-assignments, following the application of the algorithm criteria for items (a) and (b) above, will be shared equally among the health plans with less than twenty percent (20%) of the regional membership. The health plan with the highest evaluation score (determined by the State of Missouri) will receive the first member.

f. If all health plans have at least twenty percent (20%) and less than sixty percent (60%) of the membership within each region, the health plans shall equally share in the allocation from the auto-assignment process following the application of the algorithm criteria for items (a) and (b) above.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

g. The enrollment percentage by health plan and by region will be calculated on a monthly basis. If the enrollment percentage by health plan and by region necessitates a change in the auto-assignment algorithm, the change will be implemented on the first business day of the following month and will remain in effect until the enrollment percentages trigger another change in the application of the auto-assignment algorithm. Actual enrollment will be determined based on each health plan's enrollment market share during the last week of each month and reported to each health plan.

2.12.5 **Automatic Re-Assignment Into Health Plans**:

a. Following Resumption of Eligibility: The state agency will automatically enroll members who are disenrolled from a health plan due to loss of eligibility into the same health plan and to the same primary care provider should they regain eligibility within sixty (60) calendar days. The member will have ninety (90) calendar days from the effective date of coverage with the health plan in which to change health plans for any reason. If more than sixty (60) calendar days have elapsed, the member shall be permitted to select a health plan and primary care provider through the enrollment process.

b. Members Relocating to Another Region: The state agency will automatically enroll members who move from one region to another into the same health plan. The member will have ninety (90) calendar days from the effective date of coverage with the health plan in which to change health plans for any reason.

2.12.6 **Health Plan Lock-In**:

a. All members will have a twelve (12) month lock-in to provide a solid continuum of care. Once a member chooses a health plan or is assigned to a health plan, the member will have ninety (90) calendar days from the effective date of coverage with the health plan in which to change health plans for any reason. This applies to the member's initial enrollment and to any subsequent enrollment periods where the member changed health plans. All transfers between health plans that members request during the first ninety (90) calendar days following initial enrollment shall be granted without review by the state agency. Both the 90-day and the 12-month enrollment period begin on the same day.

b. Children in COA 4 shall be allowed automatic and unlimited changes in health plan choice as often as circumstances necessitate.

2.12.7 **Open Enrollment**:

a. The state agency shall conduct open enrollment for the contract period. If the MO HealthNet Managed Care eligible enrolled with a health plan does not make a selection during open enrollment,

the MO HealthNet Managed Care eligible shall be assigned to the health plan he/she was previously enrolled in if the health plan is a contracted health plan for the contract period.

b. If an MO HealthNet Managed Care eligible does not make a selection and was not previously enrolled in a health plan within the last sixty (60) calendar days, the MO HealthNet Managed Care eligible will be automatically assigned to a health plan in accordance with the automatic assignment algorithm defined herein.

c. Annual Open Enrollment: The state agency will give members an annual open enrollment period prior to the member's 12-month enrollment anniversary date with the health plan. The state agency shall provide an open enrollment notice to members at least sixty (60) calendar days before each annual enrollment opportunity.

2.12.8 **Suspension of and/or Limits on Enrollments**: The state agency reserves the right to suspend or limit enrollment into a health plan. In the event the health plan's enrollment reaches sixty percent (60%) of the total enrollment in the region, the health plan will not be offered as a choice for enrollment nor will the health plan receive members through the automatic-assignment algorithm. However, the health plan may receive new members as a result of: newborn enrollments; reassignments when a member loses and regains eligibility within a sixty (60) day period; assignments/selection when other family or case members are members of the health plan; the need to ensure continuity of care for the member; or determination of just cause by the state agency. An evaluation of a health plan's total enrollment in the region shall take place during the last week of each month and will be reported to each health plan.

2.12.9 During the enrollment process, members will be asked if English is their main language. If English is not the member's main language, the member will be asked to identify that language. The information gathered by the state agency will be shared with the health plan.

2.12.10 **Health Plan Enrollment Procedures**:

a. The health plan shall have and implement written policies and procedures for enrolling members within five (5) business days after receiving notification of the member's anticipated enrollment date from the state agency (e.g., if the health plan is informed of a new member on a Wednesday, it must contact (in writing, by phone, or in-person) the member by the following Tuesday).

b. The health plan shall enroll any MO HealthNet Managed Care eligible that selects the health plan or is assigned with the health plan. The only exceptions shall be if:

1) The health plan's specified enrollment limit has been reached; or

2) The member was previously disenrolled from the health plan as the result of a request for disenrollment by the health plan, as allowed herein.

c. Services for New Members: The health plan shall make available the full scope of benefits to which a member is entitled immediately upon his or her enrollment.

2.12.11 **Newborn Enrollment**: The health plan shall have and implement written policies and procedures for enrolling the newborn children of members effective to the date of birth. Newborns of members enrolled at the time of the child's birth shall be automatically enrolled with the mother's health plan. The health plan shall have a procedure in place to refer newborns to the FSD to initiate eligibility determinations. A mother of a newborn may choose a different health plan for her child. However, unless a different health plan is requested, the child shall remain with the mother's health plan.

a. The mother's health plan shall be responsible for all medically necessary services provided under the comprehensive benefit package to the newborn child of an enrolled mother. The child's date of birth shall be counted as day one (1). The health plan shall provide services to the child until the child is

disenrolled from the health plan. When the newborn is enrolled by the FSD and entered into the eligibility system, the health plan shall receive capitation payment for the month of birth and for all subsequent months the child remains enrolled with the health plan.

b. In the case of an administrative lag in enrolling the newborn and costs are incurred during that period, the health plan shall hold the member harmless for those costs. The health plan shall be responsible for the cost of the newborn including medical services provided prior to completion of the State enrollment process.

2.12.12 **Enrollment and Disenrollment Updates**:

a. Daily: Every business day, the state agency shall make available, via electronic media, updates on members newly enrolled into the health plan, or newly disenrolled. The health plan shall have and implement written policies and procedures for receiving these updates and incorporating them into the health plan and health care service subcontractors' management information system each day.

b. Weekly Reconciliation: On a weekly basis, the state agency shall make available, via electronic media, a listing of current members. The health plan shall reconcile this membership list against the health plan internal records within thirty (30) business days of receipt and shall notify the state agency of any discrepancies.

2.12.13 **New Member Orientation**: The health plan shall have and implement written policies and procedures for: orienting new members to their benefits; the role of the primary care provider; how to utilize services; what to do in an emergent or urgent medical situation; how to file a grievance or appeal; how to report to the FSD any changes in the status of families or members, including changes in family size, income, insurance coverage, and residence; and how to report suspected fraud, waste, and abuse.

2.12.14 **Assignment of Primary Care Provider**: The health plan shall have and implement written policies and procedures for ensuring that each of the health plan's members is assigned to a primary care provider. The process must include at least the following features:

a. The health plan shall contact the member within five (5) business days from the date of the state agency's notification to the health plan of the member's anticipated enrollment date. To the extent provider capacity exists, the health plan shall offer freedom of choice to members in making a primary care provider selection.

b. At the time of the state agency's notification to the health plan, the health plan shall assign a primary care provider taking into consideration factors such as current provider relationships, language needs (to the extent they are known), and area of residence. When contacting the member, the health plan shall provide the member with (1) the primary care provider's name, location, and telephone number, and (2) options for selecting a primary care provider other than the primary care provider assigned to the member. The health plan shall inform the member that he/she has fifteen (15) calendar days to choose another primary care provider if they do not approve of the primary care provider assigned to them, and if they have not notified the health plan of their preferred primary care provider within that timeframe, the member will remain with the primary care provider previously assigned to the member.

c. Prior to becoming effective with the health plan, if a member does not select a primary care provider or the health plan has not already assigned a primary care provider to the member at the time of notification from the state agency of the member's anticipated enrollment date, the health plan shall make an automatic assignment, taking into consideration such known factors as current provider relationships, language needs (to the extent they are known), and area of residence. The health plan shall then notify the member in writing of his or her primary care provider's name, location, and office telephone number. The member must have a primary care provider assigned by the time the member is effective with the health plan. If circumstances are such that the member does not have a

primary care provider assigned on the effective date with the health plan, the health plan shall not deny services or payment of any service.

d. The health plan shall submit to the state agency the methodology utilized by the health plan to assign primary care providers to members.

2.12.15 **Identification Cards**: The member will receive two (2) identification cards.

a. The state agency will issue an identification card to all MO HealthNet eligibles. This card is not proof of eligibility, but to be used as a key for accessing the State's electronic eligibility verification systems by MO HealthNet enrolled providers. These systems will contain the most current information available to the state agency, including specific information regarding health plan enrollment. There will be no health plan specific information printed on the card.

b. The health plan shall issue a membership card that contains information more specific to the health plan. At a minimum, the health plan issued membership card must contain the member's name, the State Departmental Client Number (DCN), primary care provider name and telephone number, instructions for emergencies, and other relevant toll free lines for access such as behavioral health, dental, and nurse advice lines. The health plan issued membership card must be issued to the member prior to the member's effective date of coverage with the health plan. Upon selection of or assignment to a health plan, the effective date for pregnant women shall be seven (7) calendar days in the future and the effective date for other members shall be fifteen (15) calendar days in the future. Exceptions apply to this policy for newborns and emergency enrollments. The state agency recognizes those exceptions and such enrollment materials may be produced as expeditiously as possible, but no later than fifteen (15) calendar days from the notification of the enrollment.

2.12.16 **Member Handbook**: The health plan shall mail a member handbook, and other written materials with information on how to access services, to all members within ten (10) business days of being notified of their future enrollment with the health plan.

a. The member handbook shall be written in compliance with the requirements for written materials specified herein.

b. On an annual basis, the health plan shall review the member handbook, revise as necessary, and document that such review occurred.

c. At a minimum, the member handbook shall include the information and items listed below. The health plan may include some of the following information as inserts to the member handbook. The health plan shall include certain passages and language provided by the state agency in the member handbook. The health plan shall comply with all changes regarding member handbook content specified by the state agency in the time period defined by the state agency.

1) Table of contents.

2) Information about choosing and changing primary care providers, types of providers that serve as primary care providers (including information on circumstances under which a specialist may serve as a primary care provider), and the roles and responsibilities of primary care providers.

3) Information about the importance of and how to report status changes such as family size changes, relocations out of county or out of state, etc.

4) A listing of the members' rights and responsibilities as described herein.

5) Appointment procedures and the appointment standards described herein.

6) Notice that the adult member must present the MO HealthNet identification card (or other documentation provided by the state agency demonstrating MO HealthNet eligibility), as well as the health plan membership card, in order to access non-emergency services, and a warning that any transfer of the identification card or membership card to a person other than the adult member for the purpose of using services constitutes a fraudulent act by the adult member. Prior to seeking non-emergency services, the adult member must have a health plan issued membership card. If the adult member does not have a health plan issued membership card, the adult member must request one from the health plan they are enrolled in.

7) A description of all available health plan services, an explanation of any service limitations or exclusions from coverage, and a notice stating that the health plan shall be liable only for those services authorized by the health plan.

8) A description of all available services outside the comprehensive benefit package. Such information shall include information on where and how members may access benefits not available under the comprehensive benefit package.

9) The definition of medical necessity used in determining whether benefits will be covered.

10) A description of all prior authorization or other requirements for treatments and services.

11) A description of utilization review policies and procedures used by the health plan.

12) An explanation of a member's financial responsibility for payment when services are provided by an out-of-network provider or by any provider without required authorization or when a procedure, treatment, or service is not covered by the MO HealthNet Managed Care Program.

13) Notice that a member may receive services from an out-of network provider when the health plan does not have an in-network provider with appropriate training and experience to meet the particular health care needs of the member and the procedure by which the member can obtain such referral.

14) Notice that a member with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral.

15) Notice that a member with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request a specialist responsible for providing or coordinating the member's medical care and the procedure for requesting and obtaining such a specialist.

16) Notice that a member with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and the procedure by which such access may be obtained.

17) A description of the mechanisms by which members may participate in the development of the policies of the health plan.

18) Notice of all appropriate mailing addresses and telephone numbers to be utilized by members seeking information or authorization.

19) Procedures for disenrollment, including an explanation of the member's right to disenroll with and without cause.

20) Information on how to contact member services and a description of its function.

21) Information on grievance, appeal, and State fair hearing procedures and timeframes. Such information shall include:

- The right to file grievances and appeals;
- The requirement 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 procedures for exercising the rights to appeal or request a State fair hearing;
- That the member may represent himself or use legal counsel, a relative, a friend, or other spokesperson;
- The specific regulations that support or the change in Federal or State law that requires the action; and
- 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.
- The following information about the member's right to request a State fair hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted:
  - ➢ A member may request a State fair hearing within ninety (90) calendar days from the health plan's notice of action; and
  - ➢ The state agency must reach its decisions within the specified timeframes:
    - ✓ For standard resolution: within ninety (90) calendar days of the date the member filed the appeal with the health plan if the member filed initially with the health plan (excluding the days the member took to subsequently file for a State fair hearing) or the date the member filed for direct access to a State fair hearing.
    - ✓ For expedited resolution (if the appeal was heard first through the health plan appeal process): within three (3) business days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process but was not resolved using the health plan's expedited appeal timeframes, or was resolved wholly or partially adversely to the member using the health plan's expedited appeal timeframes.
    - ✓ For expedited resolution (if the appeal was made directly to the State fair hearing process without accessing the health plan appeal process): within three (3) business days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

- Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.

22) How to report suspected fraud, waste, and abuse activities, including the Medicaid Fraud Control Unit (MFCU) fraud, waste, and abuse hotline number.

23) Information about the case management program to include that the member may request to be screened for case management at any time.

24) Information about the disease management programs.

25) Pharmacy dispensing fee requirements (if applicable), including a statement that care shall not be denied due to lack of payment of pharmacy dispensing fee requirements.

26) Information on how to access the provider network directory on the health plan's website and how to request a hard copy of the directory.

27) A description of after-hours and emergency coverage. This description shall include the extent to which, and how, after-hours and emergency coverage are provided, including the following: (a) What constitutes an emergency medical condition, emergency services, and post-stabilization services; (b) The fact that prior authorization is not required for emergency services; (c) The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; (d) The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered herein; (e) The fact that the member has a right to use any hospital or other setting for emergency care; and (f) The post-stabilization care services rules specified herein.

28) Information on how to obtain emergency transportation and non-emergency medically necessary transportation.

29) Information on EPSDT services including immunization and blood lead testing guidelines designated by the state agency.

30) Information on maternity, family planning, and sexually transmitted diseases services.

31) Information on behavioral health and substance abuse services, including information on how to obtain such services, the rights the member has to request such services, and how to access services when in crisis, including the toll free number to be used to access such services.

32) Information on travel distance standards.

33) Information on how to obtain services when out of the member's geographic region and after-hours coverage.

34) A statement that the health plan shall protect its members in the event of insolvency and that the health plan shall not hold its members liable for any of the following:

    - The debts of the health plan in the case of health plan insolvency;

    - Services provided to a member in the event the health plan failed to receive payment from the state agency for such service;

- Services provided to a member in the event a health care provider with a contractual referral, or other type arrangement with the health plan, fails to receive payment from the state agency or the health plan for such services; or

- Payments to a provider that furnishes covered services under a contractual referral, or other type arrangement with the health plan in excess of the amount that would be owed by the member if the health plan had directly provided the services.

35) A statement that any member that has a worker's compensation claim, or a pending personal injury or medical malpractice law suit, or has been involved in an auto accident, should immediately contact the health plan.

36) A statement that if a member has another health insurance policy, all prepayment requirements must be met as specified by the other health insurance plan and that the member must notify the health plan of any changes to their other health insurance policy. The member can contact the health plan with any questions.

37) Information on the Health Insurance Premium Payment (HIPP) program which pays for health insurance for members when it is determined cost effective.

38) Information on contributions the member can make towards his or her own health, appropriate and inappropriate behavior, and any other information deemed essential by the health plan or the state agency including the member's rights and responsibilities.

39) Information on the availability of multilingual interpreters and translated written information, how to access those services, and a statement that there is no cost to the member for these services.

40) Information on the procedures that will be utilized to notify members affected by termination or change in benefits, services, or service delivery office/site.

41) A statement that the health plan shall provide information on the health plan's physician incentive plans to any member upon request. Enrollment materials/member handbooks should annually disclose to members their right to adequate and timely information related to physician incentives.

42) With respect to advance directives, language describing:

    - The members' rights under the law of the State;

    - The health plan's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience; and

    - That complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.

43) A description of the additional information that is available upon request, including the availability of information on the structure and operation of the health plan.

44) A statement that the member has the right to obtain one free copy of his or her medical records annually and how to make the request.

45) Information on how to request and obtain an Explanation of Benefits (EOB).

d. The health plan shall submit the member handbook to the state agency for approval prior to distribution to members. The health plan shall make modifications in member handbook language if ordered by the state agency so as to comply with the member handbook requirements.

2.12.17 **Provider Directory**: The health plan shall make available on its website an up-to-date searchable provider directory. The directory on the website shall be updated at least monthly. The directory shall include the names, specialty, telephone numbers, service site address(es), panel status (accepting new patients or not accepting new patients), and languages spoken of all providers. For physicians, this listing shall also include board certification status. The health plan shall notify all enrollees of their right to request and obtain this information at least once a year. The health plan shall have printed hard copies available of the provider directory which shall be mailed within forty-eight (48) hours of a member request for a hard copy version of the provider directory.

2.12.18 **Disenrollment**:

a. The state agency shall monitor, and approve or disapprove all transfer requests for just cause, within sixty (60) calendar days subject to a medical record review. The state agency may disenroll members from a health plan for any of the following reasons:

1) Selection of another health plan during open enrollment, the first ninety (90) calendar days of enrollment, or for just cause.

2) Change of residence that places the member outside of the regions covered by this contract.

3) To implement the decision of a hearing officer in a grievance proceeding by the member against the health plan, or by the health plan against the member.

4) Loss of eligibility for either MO HealthNet Fee-For-Service or MO HealthNet Managed Care.

5) Member exercises choice to voluntarily disenroll, or opt out, as specified herein under MO HealthNet Managed Care Program eligibility groups.

b. **Member Requests**: A member may request to disenroll from a health plan for reasons that include, but are not limited to:

1) Member requests health plan transfer during open enrollment.

2) Member requests health plan transfer during the first ninety (90) days enrolled in the health plan.

3) Just cause reasons that include:

- Transfer is the resolution to a grievance or appeal;

- Primary care provider or specialist with whom the member has an established patient/provider relationship does not participate in the health plan but does participate in another health plan. An existing patient/provider relationship is one in which the member saw that provider at least once in the prior year or the provider that the member has seen most recently (except in the case of an emergency). Transfers to another health plan will be permitted when necessary to ensure continuity of care;

- Member is pregnant and her primary care provider or obstetrician does not participate in the health plan but does participate in another health plan;

- Member is a newborn and the primary care provider or pediatrician selected by the mother does not participate in the health plan but does in another health plan;

- An act of cultural insensitivity that negatively impacts the member's ability to obtain care and cannot be resolved by the health plan;

- Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs;

- Transfer to another health plan is necessary to correct an error made by the enrollment broker or the state agency during the previous assignment process;

- May also request transfer in order for all family members to be enrolled with the same health plan; and

- When the state imposes sanctions on a health plan for non-performance of contract requirements.

c. Member Requests from Children in COA 4: Children in COA 4 will be allowed automatic and unlimited changes in health plan choice as often as circumstances necessitate. Foster parents will normally have the decision making responsibility for which health plan shall serve the foster child residing with them; however, there will be situations where the Social Service worker or the courts shall select the health plan for a child in State custody or foster care placement.

d. Health Plan Requests:

1) The health plan may request disenrollment of members, subject to the conditions described below:

- Member persistently refuses to follow prescribed treatments or comply with health plan requirements that are consistent with Federal and State laws and regulations, as amended.

- Member consistently misses appointments without prior notification to the provider.

- Member fraudulently misuses the MO HealthNet Managed Care Program or demonstrates abusive or threatening conduct. Giving or loaning a member's membership card to another person, for the purpose of using services, constitutes a fraudulent action that may justify a health plan's request to disenrollment the member.

- Member requests a home birth service.

2) The health plan shall not initiate disenrollment:

- Because of a medical diagnosis or the health status of a member;

- Because of the member's attempt to exercise his or her rights under the grievance system;

- Because of pre-existing medical conditions or high cost medical bills or an anticipated need for health care;

- Due to behaviors resulting from a physical or behavioral health condition; or

- Due to race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

3) Prior to requesting a disenrollment or transfer of a member, the health plan shall document at least three (3) interventions over a period of ninety (90) calendar days which occurred through treatment, member education, coordination of services, and case management to resolve any difficulty leading to the request, unless the member has demonstrated abusive or threatening behavior in which case only one (1) attempt is required. The health plan shall cite at least one (1) of the above examples of good cause before requesting that the state agency disenroll that member. If the health plan intends to proceed with disenrollment during the ninety (90) calendar day period, the health plan shall give a notice citing the appropriate reason to both the member and the state agency at least thirty (30) calendar days before the end of the ninety (90) calendar day period. The health plan shall document all notifications regarding requests for disenrollment.

   - Members shall have the right to challenge a health plan initiated disenrollment to both the state agency and the health plan through the appeal process within ninety (90) calendar days of the health plan's request to the state agency for disenrollment of the member. When a member files an appeal, the process must be completed prior to the health plan and the state agency continuing disenrollment procedures.

   - Within fifteen (15) working days of the final notification (after no appeal or a final hearing decision), members shall be enrolled in another health plan or transferred to another provider.

4) If the health plan recommends disenrollment or transfer for reasons other than those stated above, the State shall consider the health plan to have breached the provisions and requirements of the contract and may be subject to sanctions as described herein.

e. Disenrollment Effective Dates: Member disenrollments outside of the open enrollment process shall become effective on the date specified by the state agency. The health plan shall have written policies and procedures for complying with state agency disenrollment orders.

f. Hospitalization at the Time of Enrollment or Disenrollment:

1) With the exception of newborns, the health plan shall not assume financial responsibility for members who are hospitalized in an acute setting on the effective date of coverage until an appropriate acute inpatient hospital discharge. If the member is in the MO HealthNet Fee-For-Service Program at the time of acute inpatient hospitalization on the effective date of coverage, the member shall remain in the fee-for-service program until an appropriate acute inpatient hospital discharge. Members, including newborn members, who are in another health plan at the time of acute inpatient hospitalization on the effective date of coverage, shall remain with that health plan until an appropriate acute inpatient hospital discharge. Members, including newborn members, who are hospitalized in an acute setting, shall not be disenrolled from a health plan until an appropriate acute inpatient hospital discharge, unless the member is no longer MO HealthNet Fee-For-Service or MO HealthNet Managed Care eligible or opts out.

2) For the purpose of a member moving from one health plan to another health plan, in addition to acute inpatient hospitalizations, admissions to facilities that provide a lower level of care in lieu of an acute inpatient admission may be considered as an acute inpatient hospitalization for purposes of this section. The state agency reserves the right to determine if such an admission qualifies as an acute inpatient hospitalization. Only acute inpatient hospitalization shall apply when a new member moves from the MO HealthNet Fee-For-Service Program to MO HealthNet Managed Care. The health plan shall provide timely notification to the state agency

of a member's acute inpatient hospitalization on the effective date of coverage to effect a retroactive/prospective adjustment in the coverage dates for MO HealthNet Managed Care.

2.13 Marketing and Member Education:

2.13.1 **MO HealthNet Managed Care Marketing and Member Education Guidelines**: The health plan shall educate MO HealthNet Managed Care members, subject to the restrictions and definitions outlined herein. Education activities are efforts directed to current members to provide knowledge or skills. The health plan may conduct marketing activities for MO HealthNet Managed Care members, subject to the restrictions and definitions outlined herein. Marketing campaigns are efforts directed to an audience of members and potential health plan members to retain or increase health plan membership. The health plan shall comply with all marketing and member education requirements stated herein.

a. The health plan shall advise the health plan's subcontractors of these marketing guidelines and ensure that subcontractors adhere to them. No subcontractor shall operate to relieve the health plan of its obligations. The health plan shall have and implement written procedures to ensure subcontractor notification and compliance with these marketing guidelines.

b. The health plan shall use pre-approved MO HealthNet Managed Care information and materials for presentations or interviews with print and electronic media.

c. The health plan shall make an effort to ensure that presentations shall be available to maximize consumer access to information, including presentation after normal work hours, and at sites other than the FSD offices, such as WIC sites, Head Start centers, health fairs, etc.

d. The health plan shall market to the entirety of the regions covered by the contract.

e. The health plan shall ensure that in-network providers provide equal representation of <u>all</u> contracted health plans and shall not favor one health plan over another in displayed information. The in-network providers may display brochures and other materials from one health plan even though all health plans have not provided similar materials.

f. The health plan shall only distribute approved material to local FSD offices. The health plan shall supply current materials and remove their outdated materials in public areas at the FSD offices.

g. The health plan shall request state agency prepared mandatory MO HealthNet Managed Care materials from the state agency. The health plan and its subcontractors shall make the general public aware of the MO HealthNet program by providing any of the following:

1) General MO HealthNet eligibility information;

2) MO HealthNet applications to complete and mail; or

3) Links to web applications.

2.13.2 **State Review**: The health plan shall:

a. Submit its proposed marketing plan, all marketing materials, and member education materials to the state agency for written approval prior to use. The state agency shall only consider the marketing plan and materials submitted by the health plan (not subcontractors). The health plan shall submit all materials in mock camera-ready form. When submitting marketing and education materials for approval, the health plan shall indicate how and when the material will be used, the timeframes for the use, and the media to be used for distribution if approved. The state agency shall approve, disapprove, or require modifications of education and marketing materials. The state agency shall review and respond as soon as possible, but within thirty (30) calendar days of receipt by the state

agency. Marketing and education materials are deemed approved if a response from the state agency is not returned within thirty (30) calendar days following receipt of the materials by the state agency. The health plan shall engage in only those marketing activities which are prior approved in writing.

b. Submit to the state agency all materials used by in-network providers to advise members of the health plans with which they have contracts. The health plan shall provide the following listing of what constitutes approved material to in-network providers:

1) A list of all health plans with which they have contracts;

2) A letter to previous fee-for-service recipients who may be eligible for MO HealthNet Managed Care, informing them of all health plan(s) with which the provider has contracted;

3) A display of all contracted health plan provided marketing and health education materials in an equal fashion;

4) A listing of all contracted health plan phone numbers; and

5) Displaying enrollment helpline phone number.

c. Correct problems and errors with the marketing plan and/or materials as identified by the state agency. The health plan shall submit to the state agency a written, corrected marketing plan or revised material within ten (10) business days following receipt date of the written notice from the state agency.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

d. If the health plan is new to the Managed Care Program, the state agency shall supply the health plan with a list of marketing and member education materials, in order of priority, for expedient review upon contract award.

e. Provide notice to the state agency, or have prior written approval from the state agency, in certain situations to sponsor or participate in community activities, programs, or events.

1) Community activities are defined for the purpose of this document as: activities where people come together to learn or ask questions about health care benefits, responsibilities, and procedures. These community activities require no notice to the state agency, except when held at provider sites. At community activities, the health plan shall only use materials approved by the state agency and must adhere to the ban on engaging in enrollment activities required herein.

2) Community activities at provider sites require a seven (7) calendar day notice to the state agency prior to sponsoring or participating in an activity. Provider sites may include, but are not limited to local public health agencies, provider clinics, hospitals, FQHC, RHC, CMHC, etc.

3) The health plan may offer the availability of gifts no greater than $10 in value, and only if such gifts are offered during any community activity (e.g. health fair). The nominal items must be offered to all individuals attending the community activity. The gifts must be directly and obviously health related or limited to printed materials (e.g. T-shirts, pens or pencils, caps, mugs, key chains, etc.). All items must have prior written approval by the state agency and written proof of cost per unit must be provided by the health plan to the state agency prior to approval. Once an item is approved, the item does not have to be re-approved for additional community activities. Advertising the availability of such gifts through mailings, TV or radio, posters, and other promotions or publicity is prohibited.

2.13.3 **Prohibited Activities**: The health plan shall not:

a. Use the state agency's or the Department of Social Services' name, logo, or other identifying marks on any of the materials produced or issued without the prior written approval of the state agency.

b. Use any report, graph, chart, picture, or other document produced and included in whole or in part under the MO HealthNet Managed Care contract which is subject to copyright or the subject of any application for copyright by or on behalf of the health plan.

c. Practice door-to-door, face-to-face, telephonic, or other "cold call" marketing. Cold call marketing means any unsolicited personal contact by the health plan with a potential member for the purpose of marketing as defined in this paragraph. The offerings of cash, prizes, other items for material gain, or other insurance products as an award for enrollment are prohibited, though the health plan may offer additional health benefits as described herein.

d. Offer raffles or conduct lotteries. Door prizes may be offered within the parameters and limits specified for participation in community activities, programs, or events.

e. Conduct or participate in health plan enrollment, disenrollment, transfer, or opt out activities. The health plan, any subcontractors, and the providers shall not influence a member's enrollment. Prohibited activities include:

   1) Requiring or encouraging the member to apply for an assistance category not included in MO HealthNet Managed Care;

   2) Requiring or encouraging the member and/or guardian to use the opt out as an option in lieu of delivering health plan benefits;

   3) Mailing or faxing MO HealthNet Managed Care enrollment forms;

   4) Aiding the member in filling out health plan enrollment forms;

   5) Aiding the member in completing on-line health plan enrollment;

   6) Photocopying blank health plan enrollment forms for potential members;

   7) Distributing blank health plan enrollment forms;

   8) Participating in three-way calls to the MO HealthNet Managed Care enrollment helpline;

   9) Suggesting a member transfer to another health plan; or

   10) Other activities in which the health plan, its representatives, or in-network providers are engaged in activities to enroll a member in a particular health plan or in any way assisting a member to enroll in a health plan (their own or another).

f. Use testimonial materials and/or celebrity endorsements of the health plan or as an enrollment inducement.

g. Describe or list covered benefits in any way other than according to the current MO HealthNet Managed Care contract. The health plan may not verbally or in writing identify or portray covered benefits as enhanced, additional, or free.

h. Develop marketing materials that are inaccurate or mislead, confuse, defraud, or deceive MO HealthNet Managed Care eligibles, or otherwise violate Federal or State consumer protection laws or regulations or contain any assertion or statement (whether written or oral) that:

1) The participant must enroll with the health plan in order to obtain MO HealthNet benefits or in order not to lose benefits. (The health plan may include information on any additional health benefits the health plan provides.)

2) The health plan is endorsed by CMS, the Federal or State government, or similar entity.

2.14 Member Services: The health plan shall provide all member services as described herein. The health plan shall have and implement member services policies and procedures that address all member services activities.

2.14.1 **Member Services Staff**: The health plan shall provide adequately trained member services staff to operate at least nine (9) consecutive hours during the hours of 7:00 a.m. through 7:00 p.m. (e.g., 8:00 a.m. through 5:00 p.m.), Monday through Friday. The health plan may observe State designated holidays or the holidays designated in the health plan's awarded proposal for its operation of member services. If the health plan observes holidays different than the State's, the health plan shall obtain the prior written approval of the state agency. Contract award does not constitute the state agency's approval or acceptance of the holiday schedule proposed in the health plan's awarded proposal. The health plan's member services staff shall be responsible for the following:

a. Explaining the operation of the health plan and assisting members in the selection of a primary care provider.

b. Educating the family about Managed Care including the way services typically are accessed under Managed Care and the role of the primary care provider.

c. Specifying member's rights and responsibilities.

d. Explaining covered benefits.

e. Assisting members to make appointments and obtain services.

f. Arranging medically necessary transportation for members.

g. Handling, recording, and tracking member inquiries promptly and timely.

h. Assisting in changing primary care providers.

i. Providing the following information to members requesting the names of providers:

1) Whether the provider currently participates in the health plan;

2) Whether the provider is currently accepting new patients; and

3) Any restrictions on services, including any referral or prior authorization requirements the member must meet to obtain services from the provider.

j. Informing members about fraud, waste, and abuse policies and procedures and providing assistance in reporting suspected fraud, waste, and abuse.

2.14.2 **Toll-Free Telephone Line(s)/Call Center**:

a. The health plan shall maintain a toll-free member services telephone number to respond to member questions, comments, and inquiries. During non-business hours when the member service telephone number is not staffed, the health plan shall have an automated system or answering service. The automated system or answering service shall provide callers with: operating instructions on what to do in case of emergency, the MFCU fraud and abuse hotline number, an option to talk directly with a nurse or other clinician or behavioral health crisis worker, and instructions on how to leave a message and when that message will be returned. The health plan shall 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.

b. The health plan shall operate a twenty-four (24) hours, seven (7) days per week toll-free nurse hotline to provide to its members direct contact with qualified licensed clinical staff. Recorded messages are not acceptable for this hotline.

c. The health plan shall operate a twenty-four (24) hours, seven (7) days per week behavioral health crisis line that is staffed by QBHPs. Recorded messages are not acceptable for this hotline.

d. The health plan may use the same number for all toll-free telephone lines/call centers or may develop different phone numbers. If the same number is used for all lines, the call prompts shall be clear so as to ensure that members reach the appropriate individual.

e. All toll free telephone lines and call centers shall meet, at a minimum, the following call center standards:

1) Ninety (90) percent of calls are answered within thirty (30) seconds;

2) The call abandonment rate is five percent (5%) or less;

3) The average hold time is two (2) minutes or less; and

4) The blocked call rate does not exceed one percent (1%).

f. All toll-free telephone lines and call centers shall provide twenty-four (24) hours per day voice and telecommunications device services for hearing impaired members and language translation services in all languages, not just those languages that meet the threshold for written translation requirements.

g. The health shall have policies and procedures regarding the operation of these toll-free telephone lines/call centers. The health plan shall make the policies and procedures available in an accessible format upon request.

2.14.3 **Provider Listing**: The health plan's member services staff must have available a complete and up-to-date list of the in-network providers in the health plan provider network. The health plan shall have and implement a policy and procedure for updating the provider listing at least monthly. This complete and up-to-date provider listing can be either hard copy or electronic.

2.14.4 **Interpreter Services**: The health plan shall make interpreter services available as necessary to ensure that members are able to communicate with the health plan and providers and receive covered benefits. The health plan shall use certified interpreters. The health plan shall inform members of the availability of interpreter services, how to access them, and that there is no charge for the services.

2.14.5 **Internet Presence/Website**: The health plan shall have a member portal on its website that is available to all members which contains accurate, up-to-date information about the health plan, services provided, the provider network, FAQs,, and contact phone numbers and e-mail addresses. The section of the

website relating to MO HealthNet shall comply with all marketing policies and procedures and requirements for written materials described herein. As part of the member services policies and procedures, the health plan shall describe its activities to ensure the website is updated regularly and contains accurate information.

2.14.6 **Requirements for Written Materials**:

a. The health plan shall develop appropriate methods for communicating with visual and hearing impaired members and accommodating the physically disabled. The health plan shall offer members standard materials, such as the member handbook and enrollment materials in alternative formats (i.e., large print, Braille, cassette, and diskette) immediately upon request from members with sensory impairments.

b. If the health plan has more than two hundred (200) members, or five percent (5%) of its program membership (whichever is less), who speak a single language other than English as a primary language, the health plan shall make available general services and materials, such as the health plan's member handbook, in that language. The health plan shall include, on all materials, language blocks in those languages that tell members that translated documents are available and how to obtain them.

c. All written materials shall be worded such that the materials are understandable to a member who reads at the sixth (6th) grade reading level. Suggested reference materials to determine whether this requirement is being met are the:

1) Fry Readability Index;
2) PROSE The Readability Analyst (software developed by Education Activities, Inc.);
3) Gunning FOG Index;
4) McLaughlin SMOG Index; and
5) The Flesch-Kincaid Index or other word processing software approved by the state agency.

d. The health plan shall:

1) Submit all materials, including changes or revisions, to the state agency for prior approval before being distributed. The health plan shall submit these changed materials at least thirty (30) days in advance of the scheduled distribution.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

2) Review all materials at least once a year. The health plan shall provide the state agency with documentation verifying the health plan reviewed their written materials.

3) Insert new language in the written materials and substitute in a timely manner, as outlined by the state agency, any changes in Federal or State law or regulation, as amended, as the need arises.

4) Show the tracking number and the date the state agency approved the material in the lower right-hand corner of all materials developed and printed by the health plan.

5) Use mandatory education, marketing, and member notice language provided by the state agency. The state agency shall provide such language as it deems necessary. Any publicity given to the MO HealthNet Managed Care Program or the MO HealthNet Managed Care benefits shall be released only with prior written approval by the state agency, including but not limited to: notices, pamphlets, press releases, research, reports, signs, and public notices prepared by or for the health plan.

6) Maintain a member's right to confidentiality. In particular, post cards must be folded to protect the confidentiality of the member.

2.14.7 **Changing Primary Care Providers**: The health plan shall have and implement written policies and procedures for allowing members to select or be assigned to a new primary care provider within the health plan when such a change is mutually agreed to by the health plan and member. The health plan shall allow members (except for children in COA 4) at least two (2) such changes per year; children in COA 4 may change primary care providers at will. The health plan shall inform members of the process for initiating primary care provider changes. Possible reasons for a member to change primary care providers include, but are not limited to:

a. Accessibility - transportation problems, office hours, provider does not return phone calls, or waiting times.

b. Acceptability - is attended by too many different doctors at a clinic location, uncomfortable with surroundings or location, lack of courtesy, or provider or staff attitudes.

c. Quality - treatment (medical), referral related, or provider does not explain treatment plan/diagnosis. If this is a provider problem, the member may request a primary care provider change and a second opinion.

d. Enrollment - primary care provider with whom the member has an established patient/provider relationship no longer participates in the health plan. In cases where the primary care provider no longer participates, the health plan shall allow members to select another primary care provider or make a re-assignment within fifteen (15) calendar days of the termination effective date.

e. Cultural Insensitivity - an act of cultural insensitivity that negatively impacts the member's ability to obtain care.

f. Resolution of Grievance or Appeal Process - a primary care provider change is ordered as part of the resolution to the grievance and appeal process. A member's right to request a change in a primary care provider through the grievance and appeal process or other means shall not be restricted.

2.14.8 **Member Rights and Responsibilities**:

a. Member Rights: The health plan shall include, in its member services policies and procedures, a description of how it will ensure that the rights of members are safeguarded and how the health plan will (1) comply with any applicable Federal and State laws that pertain to member rights, and (2) ensure that its staff and in-network providers take those rights into account when furnishing services to members. The members' rights include the right to:

1) Dignity and privacy. Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

2) Receive information on available treatment options. Each member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

3) Participate in decisions. Each member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

4) Be free from restraint or seclusion. Each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

5) Obtain a copy of medical records. Each member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164.

6) Freely exercise these rights. Each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the member.

b. Member Responsibilities: The health plan shall also include in its member services policies and procedures, policies that address the members' responsibilities for cooperating with providers. These member responsibility policies must be supplied in writing to all providers and members and should address the member's responsibilities for:

1) Providing, to the extent possible, information needed by providers in caring for the member;

AMENDMENT 1 RENUMBERED THE FOLLOWING PARAGRAPH:

2) Contacting their primary care provider as their first point of contact when needing medical care;

AMENDMENT 1 RENUMBERED THE FOLLOWING PARAGRAPH:

3) Following appointment scheduling processes; and

AMENDMENT 1 RENUMBERED THE FOLLOWING PARAGRAPH:

4) Following instructions and guidelines given by providers.

2.14.9 **Member Hold Harmless**: The health plan shall not hold a member liable for the following:

a. The debts of the health plan, in the event of the health plan's insolvency;

b. Services provided to the member in the event the health plan fails to receive payment from the state agency for such services;

c. Services provided to the member in the event a health care provider with a contractual referral, or other arrangement with the health plan fails to receive payment from the state agency or health plan for such services;

d. Payments to a provider that furnishes covered services under a contractual, referral, or other arrangement with the health plan in excess of the amount that would be owed by the member if the health plan had directly provided the services; or

e. In the case of insolvency, the health plan shall continue to cover services to members during insolvency for the duration of period for which payment has been made by the state agency, as well as for inpatient admissions up until discharge.

2.14.10 **Changes in Information**:

a. The health plan shall ensure that members receive written notification of changes in health plan operations that affect them at least thirty (30) calendar days before the intended effective date of the change unless otherwise noted. Examples of such changes and the notification requirements are as follows:

1) Network changes such as a new behavioral health subcontractor or other major subcontractor. Notification is required to all members.

BAFO 001 DELETED THE FOLLOWING PARAGRAPH:

2) DELETED

3) In network primary care provider moves from one in-network clinic or physician group to another. Notification is required to the affected members, seen on a regular basis, within fifteen (15) calendar days of the receipt of the move notice. The health plan must notify members of the primary care provider's new location and phone number. The member must receive new identification cards with the primary care provider's name and phone number.

4) Comprehensive benefit package changes from what is explained in the member handbook. Notification is required to all members.

5) Utilization management procedure(s) changes from what is explained in the member handbook. Notification is required to all members.

6) Prior authorization procedure(s) changes from what is explained in the member handbook. Notification is required to all members.

7) Advance directive policy changes as a result of changes in State law. Notification is required to all members.

b. All written member notifications must be prior approved by the state agency and written according to the requirements for written materials stated herein. The health plan shall include certain passages and language provided to the health plan by the state agency in the member notification. The health plan shall comply with all changes regarding member notification content specified by the state agency within the time period defined by the state agency.

2.15 Member Grievance System: The health plan shall have a system in place for members which includes a grievance process, an appeal process, and access to the state agency's fair hearing system.

2.15.1 For purposes of the health plan's member grievance system, the following definitions shall apply:

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 of the health plan to provide services in a timely manner as defined in the appointment standards described herein; or the failure of the health plan to act within timeframes for the health plan's prior authorization review process specified herein.

Appeal - A request for review of an action, as action is defined in this section.

Appeal Process - The health plan's process for handling of appeals that complies with the requirements specified herein, including, but not limited to, the procedural steps for a member to file an appeal, the process for resolution of an appeal, the right to access the State fair hearing system, and the timing and manner of required notifications.

Grievance - An expression of dissatisfaction about any matter other than an action, as action is defined in this section. 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.

Grievance Process - The health plan process for handling of grievances that complies with the requirements specified herein, including, but not limited to, the procedural steps for a member to file a grievance, the process for disposition of a grievance, and the timing and manner of required notifications.

Grievance System - The overall system in place for members that includes a grievance process, an appeal process, and access to the State fair hearing system.

Inquiry - A request from a member for information that would clarify health plan policy, benefits, procedures, or any aspect of health plan function but does not express dissatisfaction.

2.15.2 **General Requirements**: The health plan shall develop and implement written policies and procedures that detail the operation of the grievance system and provides simplified instructions on how to file a grievance or appeal and how to request a State fair hearing.

a. The policies and procedures must be approved by the state agency prior to implementation.

b. The policies and procedures shall be approved by the health plan's governing body and be the direct responsibility of the governing body.

c. The policies and procedures shall identify specific individuals who have authority to administer the grievance system policies.

d. The health plan shall distribute to members upon enrollment a flyer explaining the grievance system. This flyer shall contain specific instructions about how to contact the health plan's member services, and shall identify the person from the health plan who receives and processes grievances and appeals. This flyer can be distributed with the member handbook but it must be a stand-alone document. The grievance system flyer shall be readily available in the member's primary language. In addition, the health plan shall demonstrate that they have procedures in place to notify all members in their primary language of grievance dispositions and appeal resolutions.

e. The health plan shall also distribute the information on the grievance system to all in-network providers at the time they enter into a contract and to out-of-network providers within ten (10) calendar days of prior approval of a service or the date of receipt of a claim whichever is earlier. This information may be distributed to providers via the member flyer, a flyer designed for providers, or the grievance system policies and procedures.

f. As part of the grievance system, the health plan shall ensure that health plan executives with the authority to require corrective action are involved in the grievance and appeal processes.

g. The health plan shall thoroughly investigate each grievance and appeal using applicable statutory, regulatory, and contractual provisions, and the health plan's written policies and procedures. Pertinent facts from all parties must be collected during the investigation.

h. The health plan shall probe inquiries so as to validate the possibility of any inquiry actually being a grievance or appeal. The health plan shall identify any inquiry pattern.

i. The health plan's grievance system shall not be a substitute for the State fair hearing process. The state agency shall maintain an independent State fair hearing process as required by Federal law and regulation, as amended. The State fair hearing process shall provide members with an opportunity for a State fair hearing before an impartial hearing officer. 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. The health plan shall comply with decisions reached as a result of the State fair hearing process. Health plan members shall have the right to request information regarding:

1) The right to request a State fair hearing;

2) The procedures for exercising the rights to appeal or request a State fair hearing;

3) Representing themselves or use legal counsel, a relative, a friend, or other spokesperson;

4) The specific regulations that support or the change in Federal or State law that requires, the action;

5) The individual's right to request a State fair hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted; and

6) A State fair hearing within ninety (90) calendar days from the health plan's notice of action.

j. The State must reach its decisions within the specified timeframes:

1) Standard resolution: within ninety (90) calendar days of the date the member filed the appeal with the health plan if the member filed initially with the health plan (excluding the days the member took to subsequently file for a State fair hearing) or the date the member filed for direct access to a State fair hearing.

2) Expedited resolution (if the appeal was heard first through the health plan appeal process): within three (3) working days from the state agency's receipt of a hearing request for a denial of a service that:

- Meets the criteria for an expedited appeal process but was not resolved using the health plan's expedited appeal timeframes, or

- Was resolved wholly or partially adversely to the member using the health plan's expedited appeal timeframes.

3) Expedited resolution (if the appeal was made directly to the State fair hearing process without accessing the health plan appeal process): within three (3) business days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

2.15.3 **Record Keeping Requirements**:

a. The health plan shall log and track all inquiries, grievances, and appeals.

b. The health plan shall maintain records of grievances, whether received verbally or in writing, that include a short, dated summary of the problems, name of the grievant, date of grievance, date of decision, and the disposition. If the health plan does not have a separate log for MO HealthNet Managed Care members, the log shall distinguish MO HealthNet Managed Care members from other health plan members.

c. The health plan shall maintain records of appeals, whether received verbally or in writing, that include a short, dated summary of the issues, name of the appellant, date of appeal, date of decision, and the resolution. If the health plan does not have a separate log for MO HealthNet Managed Care members, the log shall distinguish MO HealthNet Managed Care members from other health plan members.

d. The health plan is responsible for submitting the log sheet for all inquiries, grievances, and appeals to the state agency quarterly and upon request. Please see *Complaint, Grievance and Appeal Report* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

e. The state agency may publicly disclose summary information regarding the nature of grievances and appeals and related dispositions or resolutions in consumer information materials.

2.15.4 **Notice of Action Requirements**:

a. The health plan's notice must be in writing and must meet the language and content requirements specified herein to ensure ease of understanding.

b. The health plan's notice must explain the following:

1) The action the health plan has taken or intends to take;

2) The reasons for the action;

3) The member's or the provider's right to file an appeal;

4) The member's right to request a State fair hearing;

5) The procedures for exercising the rights to appeal or request a State fair hearing;

6) The member's right to represent himself or use legal counsel, a relative, a friend, or other spokesperson;

7) The specific regulations that support or the change in federal or state law that requires the action;

8) The member's right to request a state agency hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted;

9) The circumstances under which expedited resolution is available and how to request it; and

10) The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

c. The health plan shall mail the notice to the member within the following timeframes:

1) For termination, suspension, or reduction of previously authorized covered services, at least ten (10) calendar days before the date of action. The health plan may mail a notice not later than the date of action under the following circumstances:

- The health plan has factual information confirming the death of the member;

- The health plan receives a clear, written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;

- The member's whereabouts are unknown and the post office returns health plan mail directed to the member indicating no forwarding address (refer to 42 CFR 431.231 (d) for procedures if the member's whereabouts become known);

- The member's physician prescribes a change in the level of medical care;

- The health plan may shorten the period of advance notice to five (5) calendar days before date of action if the health plan has facts indicating that action should be taken because of

probable fraud by the member and the facts have been verified, if possible, through secondary sources;

- The member's admission to an institution where he is ineligible for further services; and
- The member has been accepted for MO HealthNet services by another local jurisdiction.

2) For denial of payment decisions that result in member liability, at the time of any action affecting the claim.

3) For service authorization decisions that deny or limit services, within the timeframes required by the service accessibility standards for prior authorization specified herein.

4) For service authorization decisions not reached within the required timeframes, the notice of action must be mailed by the date that the timeframe expires.

2.15.5 **Grievance Process**:

a. A member may file a grievance either orally or in writing. A member's authorized representative including the member's provider may file a grievance on behalf of the member.

b. The health plan shall 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.

c. The health plan shall acknowledge receipt of each grievance in writing within ten (10) business days after receiving a grievance.

d. The health plan shall ensure that the individuals who make decisions on grievances are individuals who were not involved in any previous level of review or decision-making; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the state agency, in treating the member's condition or disease:

1) A grievance regarding denial of expedited resolution of an appeal; or

2) A grievance that involves clinical issues.

e. The health plan shall dispose of each grievance and provide written notice of the disposition of the grievance, as expeditiously as the member's health condition requires but shall not exceed thirty (30) calendar days of the filing date.

f. The health plan may extend the timeframe for disposition of a grievance for up to fourteen (14) calendar days if the member requests the extension or the health plan demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's interest. If the health plan extends the timeframe, the health plan shall, for any extension not requested by the member, provide 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 the 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.

2.15.6 **Appeal Process**:

a. A member may file an appeal and may request a State fair hearing within ninety (90) calendar days from the date on the health plan's notice of action. A provider, acting on behalf of the member and with the member's written consent, may file an appeal.

b. The member or provider may file an appeal either orally or in writing. Unless he or she requests expedited resolution, the member or provider must follow an oral filing with a written, signed appeal.

c. The health plan shall 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.

d. Appeals shall be filed directly with the health plan's governing body, or its delegated representatives. The governing body may delegate this authority to an appeal committee, but the delegation must be in writing.

e. The health plan shall acknowledge receipt of each appeal in writing within ten (10) business days after receiving an appeal.

f. The health plan shall ensure that the individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the state agency, in treating the member's condition or disease:

   1) An appeal of a denial that is based on lack of medical necessity; or

   2) An appeal that involves clinical issues.

g. The appeals process must provide that oral inquiries seeking to appeal are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution.

h. The appeals process must 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 shall inform the member of the limited time available for this in the case of expedited resolution.

i. The appeals process must provide the member and his or her representative with an 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.

j. The appeals process must include as parties to the appeal the member and his or her representative or the legal representative of a deceased member's estate.

k. The health plan shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed forty-five (45) calendar days from the date the health plan receives the appeal. For expedited resolution of an appeal and notice to affected parties, the health plan has no longer than three (3) working days after the health plan receives the appeal. For notice of an expedited resolution, the health plan shall also make reasonable efforts to provide oral notice.

l. The health plan may extend the timeframe for standard or expedited resolution of the appeal by up to fourteen (14) calendar days if the member requests the extension or the health plan demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's interest. If the health plan extends the timeframe, the health plan shall, for any extension not requested by the member, provide 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 the 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.

m. The written notice of the appeal resolution must include the following:

1) The results of the resolution process and the date it was completed; and

2) For appeals not resolved wholly in the favor of the members, the right to request a State fair hearing and how to do so; the right to request a continuation of 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.

n. The health plan shall establish and maintain an expedited review process for appeals when the health plan determines (for a request from the member) or the provider indicates (in making the request on the member's behalf) 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. The health plan shall ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a member's appeal.

o. If the health plan denies a member's request for expedited resolution, the health plan shall transfer the appeal to the timeframe for standard resolution specified herein and shall 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.

p. Continuation of benefits while the health plan appeal and State fair hearing are pending.

1) 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; or

- The intended effective date of the health plan's proposed action.

2) The health plan shall continue the member's benefits if the member or the provider 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 the benefits.

3) 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 the 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) calendar day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached;

- A State fair hearing officer issues a hearing decision adverse to the member; or

- The time period or service limits of a previously authorized service has been met.

4) 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.

q. 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 shall authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires.

r. 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 shall pay for those services.

2.16 Provider Services: The health plan shall provide all provider services as described herein. The health plan shall have and implement provider services policies and procedures that address all provider services activities.

2.16.1 **Provider Services Staff**: The health plan shall provide adequately trained provider services staff to operate at least nine (9) consecutive hours during the hours of 7:00 a.m. through 7:00 p.m. (e.g., 8:00 a.m. through 5:00 p.m.), Monday through Friday. The health plan may observe State designated holidays or the holidays designated in the health plan's awarded proposal for its operation of provider services. If the health plan observes holidays different than the State's, the health plan shall obtain the prior written approval of the state agency. Contract award does not constitute the state agency's approval or acceptance of the holiday schedule proposed in the health plan's awarded proposal. The health plan's provider services staff shall be responsible for the following:

a. Establishing a mechanism by which providers may determine in a timely manner whether a member is covered by the health plan and the member's primary care provider assignment;

b. Educating providers on the above mechanism's use;

c. Educating and assisting providers with the health plan service accessibility standards including but not limited to prior authorization, denial, and referral procedures;

d. Educating and assisting providers with claims submission and payment procedures;

e. Educating providers about conditions under which members may directly access services including, but not limited to, behavioral health and substance abuse, family planning, and public health services;

f. Educating providers about how a member can access emergency care and after-hour services;

g. Handling provider inquiries and complaints; and

h. Serving as a liaison between the health plan and the in-network providers and communicate at least quarterly with the in-network providers, including oversight of provider education, in service training, and orientation. Newsletter, web sites, and other media may be used to meet this requirement.

2.16.2 **Provider Telephone Lines/Call Center**:

a. The health plan shall maintain a toll-free provider services line to respond to provider questions, comments, and inquiries. During non-business hours when the provider services line is not staffed, the health plan shall have an automated system or answering service. The automated system or answering service shall provide callers with: operating instructions on what to do if seeking a prior authorization and instructions on how to leave a message and when the message will be returned. The health plan shall ensure that the voice mailbox has adequate capacity to receive all messages and that provider services staff return all calls by close of business the following business day.

b. The health plan shall operate a twenty-four (24) hours, seven (7) days per week toll-free line to provide prior authorizations and confirmations of member enrollment. Recorded messages are not acceptable for this hotline. The number for this line can be the same as the number for the provider services line, provided there are clear prompts to ensure providers are able to access the appropriate provider services or prior authorization staff.

c. All toll free telephone lines and call centers shall meet, at a minimum, the following call center standards:

1) Ninety (90) percent of calls are answered within thirty (30) seconds;

2) The call abandonment rate is five percent (5%) or less;

3) The average hold time is two (2) minutes or less; and

4) The blocked call rate does not exceed one percent (1%).

2.16.3 **Website for Providers**: The health plan shall have a provider portal on its website that is accessible to providers. The portal shall include all pertinent information including, but not limited to, the provider manual, update newsletters and information, information on obtaining prior authorizations, and information about how to contact the health plan. The health plan shall have policies and procedures in place to ensure the website is updated regularly and contains accurate information.

2.16.4 The health plan shall develop, distribute, and maintain a provider manual.

a. The health plan shall obtain and document the approval of the provider manual by the health plan's Health Plan Administrator and Medical Director and shall review the provider manual at least annually and maintain documentation verifying such.

b. The health plan shall issue a copy of the provider manual to providers at the time of inclusion in the provider network, and shall educate the provider as to its full content and usage.

c. At a minimum, the provider manual shall contain sections regarding:

1) Specific covered health services for which the provider shall be responsible, including any limitations or conditions on services;

2) The requirement that the provider implement a policy of, before providing non-emergency services to an adult MO HealthNet Managed Care member, requesting and inspecting the adult member's MO HealthNet identification card (or other documentation provided by the state agency demonstrating MO HealthNet eligibility) and health plan membership card. If the adult member doesn't produce their health plan membership card, and the provider verifies eligibility and health plan enrollment, the provider may provide service if they have notified the health plan that the member has no health plan identification card. The provider must document this verification in the member's medical record.

3) Claims submission instructions and the procedure for review of denied claims;

4) Prior authorization procedures, and referral procedures including exceptions, second, or third opinions;

5) Primary care provider responsibilities described in this contract, including the role of the primary care provider in case management;

6) Specialist/ancillary provider responsibilities;

7) Provider complaint and appeal processes including any State-determined provider appeal rights to challenge the failure of the health plan to cover a service;

8) Information on the member grievance system including**:**

- The member's right to file grievances and appeals and their requirements and timeframes for filing;
- The availability of assistance in filing;
- The toll-free numbers to file oral grievances and appeals;
- The member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the health plan's action is upheld in a hearing, the member may be liable for the cost of any continued benefits; and
- The member's right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing.
  - ➢ A member may request a State fair hearing within ninety (90) calendar days from the health plan's notice of action.
  - ➢ The State shall reach its decisions within the specified timeframes:
    - ✓ Standard resolution: within ninety (90) calendar days of the date the member filed the appeal with the health plan if the member filed initially with the health plan (excluding the days the member took to subsequently file for a State fair hearing) or the date the member filed for direct access to a State fair hearing.
    - ✓ Expedited resolution (if the appeal was heard first through the health plan appeal process): within three (3) business days from the state agency's receipt of a hearing request for a denial of a service that:
      - ▪ Meets the criteria for an expedited appeal process but was not resolved using the health plan's expedited appeal timeframes; or
      - ▪ Was resolved wholly or partially adversely to the member using the health plan's expedited appeal timeframes.
    - ✓ Expedited resolution (if the appeal was made directly to the State fair hearing process without accessing the health plan appeal process): within three (3) business days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

9) Procedure for obtaining member eligibility status;

10) Appointment/Service Accessibility Standards;

11) Multilingual and TDD availability;

12) Quality Assessment and Improvement activities and requirements;

13) Provider Credentialing requirements and standards;

14) Management and retention of medical records requirements;

15) Confidentiality requirements;

16) Advance directives requirements; and

17) Fraud, waste, and abuse guidelines, including the MFCU fraud and abuse hotline number.

d. The Provider manual may require an amendment once the Local Community Care Coordination Program (LCCCP) program application and program are approved by the state agency.

2.16.5 **Provider Disclosures**: The health plan shall request from the provider, in order to supply the state agency, the following information for each provider performing services for the health plan, using the template provided in *Provider and Subcontractor Disclosure* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/) that includes the: address, Social Security Number, Employer Identification Number, date of birth, provider type, Missouri license number or appropriate State license number, NPI (if available), and OIG exclusion status, exclusion type (if applicable), date of exclusion (if applicable), and date exclusion ends (if applicable). Following the effective date of the contract, the health plan shall provide the state agency with the Social Security Numbers of the providers. The health plan shall collect the information from the provider:

a. At the stage of provider credentialing and re-credentialing;

b. Upon execution of the provider agreement;

c. Within thirty-five (35) days of any change in ownership of the provider; and

d. At any time upon the request of the state agency for any or all of the information described in this section.

2.16.6 **Materials and Information for Out-of-Network Providers**: The health plan shall specify in writing the following to out-of-network providers at the time a service is approved to be performed by the out-of-network provider:

a. Claims submission instructions and the procedure for review of denied claims;

b. Prior authorization procedures and referral procedures including exceptions, second, or third opinions;

c. Provider complaint and appeal procedures including any State-determined provider appeal rights to challenge the failure of the health plan to cover a service.

d. The following information about the member grievance system:

1) The member's right to file grievances and appeals and their requirements and timeframes for filing;

2) The availability of assistance in filing;

3) The toll-free numbers to file oral grievances and appeals;

4) The member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the health plan's action is upheld in a hearing, the member may be liable for the cost of any continued benefits; and

5) The member's right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing:

- A member may request a State fair hearing within ninety (90) calendar days from the health plan's notice of action.

- The State shall reach its decisions within the specified timeframes:

  - Standard resolution: within ninety (90) calendar days of the date the member filed the appeal with the health plan if the member filed initially with the health plan (excluding the days the member took to subsequently file for a State fair hearing) or the date the member filed for direct access to a State fair hearing.

  - Expedited resolution (if the appeal was heard first through the health plan appeal process): within three (3) business days from the state agency's receipt of a hearing request for a denial of a service that:

    - Meets the criteria for an expedited appeal process but was not resolved using the health plan's expedited appeal timeframes, or

    - Was resolved wholly or partially adversely to the member using the health plan's expedited appeal timeframes.

  - Expedited resolution (if the appeal was made directly to the State fair hearing process without accessing the health plan appeal process): within three (3) business days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

e. Procedure for obtaining member eligibility status;

f. Multilingual and TDD availability; and

g. Confidentiality requirements.

2.17 Provider Complaints and Appeals: The health plan shall establish a provider complaint and appeal process that provides for the timely and effective resolution of any disputes between the health plan and providers. This system is specific to providers and does not replace the member grievance system which allows a provider to submit a grievance or an appeal on behalf of a member. When a provider submits a grievance or appeal on behalf of a member, the requirements of the member grievance system shall apply.

2.17.1 **Definitions**: For purposes of this document, the following definitions shall apply:

Complaint - A verbal or written expression by a provider which indicates dissatisfaction or dispute with health plan policy, procedure, claims, or any aspect of health plan functions. All complaints must be logged and tracked whether received by telephone, in person, or in writing.

Provider Appeal - The mechanism which allows the right to appeal actions of the health plan to a provider who:

a. Has a claim for reimbursement or request for authorization of service delivery denied or not acted upon with reasonable promptness; or

b. Is aggrieved by any rule or policy or procedure or decision by the health plan.

2.17.2 **Policies and Procedures**:

a. The health plan shall have and implement written policies and procedures which detail the operation of the provider complaint and appeal process. The policies and procedures shall be approved by the health plan governing body and be the direct responsibility of the governing body. The health plan shall submit the policies and procedures to the state agency for prior approval.

b. The policies and procedures shall include, at a minimum:

1) A description of how providers file a complaint or provider appeal, including whether it must be in writing;

2) Information on the amount of time a provider has to file and the resolution timeframe;

3) A process for thoroughly investigating each complaint and appeal using applicable statutory, regulatory, and contractual provisions, and for collecting pertinent facts from all parties during the investigation;

4) A description of the methods used to ensure that health plan executives with the authority to require corrective action are involved in the complaint and appeal process;

5) A process for giving providers (or their representatives) the opportunity to present their cases in person to the health plan's appellate body; and

6) Identification of specific individuals who have authority to administer the provider complaint and appeal process.

c. The health plan shall distribute an information packet to providers containing the complaint and appeal policies and procedures; specific instructions regarding how to contact the health plan's provider services staff; and contact information for the person from the health plan who receives and processes complaints and provider appeals. The health plan shall distribute the policies and procedures to in-network providers at the time of subcontract and to out-of-network providers with the remittance advice of the processed claim.

d. The health plan shall include a description of the provider complaint and appeal process in the provider manual.

2.17.3 **Record Keeping Requirements**:

a. The health plan shall maintain records of complaints that include a short, dated summary of each of the questions or problems, name of the complainant, date of complaint, the response, and the resolution. If the health plan does not have a separate log for in-network providers, the log shall distinguish in-network providers from other health plan providers.

b. The health plan shall maintain provider appeal records that include a copy of the original provider appeal, the response, and the resolution. This system shall distinguish in-network providers from other health plan providers and identify the appellant and the date of filing.

2.18 Quality Assessment and Improvement:

2.18.1 The state agency's quality assessment and improvement program shall consist of internal monitoring by the health plan, oversight by Federal and State governments, and evaluations by an independent, external review organization. The state agency regulates the quality assessment and improvement functions of the health plan. The quality assessment and improvement program will be annually evaluated for effectiveness. This process includes obtaining input from stakeholders, the State Quality Assessment &

Improvement Advisory Group, Consumer Advisory Committee, and approval from CMS prior to implementation. In the instance there is significant change in outcome or indicator status that is not self-limiting and impacts on more than one area of the populations' health status, modifications will be made to the reporting process. These modifications may include changes to the monthly, quarterly, semi-annual, and annual MO HealthNet Managed Care health plan reports, on-site review topics, and MO HealthNet Managed Care performance measures. The health plan shall attend and participate in the state agency's Quality Assessment & Improvement Advisory Group meetings. The health plan shall adhere to the requirements contained within the *State of Missouri Quality Improvement Strategy for Medicaid Managed Care Program* located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/).

2.18.2 The health plan shall comply with all the state agency's quality assessment and improvement programs as described herein. The health plan shall participate in the state agency's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The health plan shall be held accountable for the ongoing monitoring, evaluation, and actions as necessary to improve the health of its members and the care delivery systems for those members. The health plan shall be held accountable for the quality of care delivered by providers. The health plan shall have a quality assessment and improvement program which integrates an internal quality assessment process that conforms to Quality Improvement System for Managed Care (QISMC) and additional current standards and guidelines prescribed by CMS. The health plan shall have a quality assessment and improvement program composed of:

a. An internal system of monitoring, analysis, evaluation, and improvement of the delivery of care that includes care provided by all providers;

b. Designated staff with expertise in quality assessment, utilization management, and continuous quality improvement;

c. Written policies and procedures for quality assessment, utilization management, and continuous quality improvement that are periodically analyzed and evaluated for impact and effectiveness;

d. Results, conclusions, team recommendations, and implemented system changes which are reported to the health plan's governing body at least quarterly; and

e. Reports that are evaluated, recommendations that are implemented when indicated, and feedback provided to providers and members.

2.18.3 The health plan shall meet program standards for monitoring and evaluation of systems to meet Federal and State regulations. The health plan shall implement a Quality Improvement strategy that includes components to monitor, evaluate, and implement the contract standards and processes to improve:

a. Quality management;

b. Utilization management;

c. Records management;

d. Information management;

e. Case management;

f. Member services;

g. Provider services;

h. Organizational structure;

i. Credentialing;

j. Network performance;

k. Fraud, waste, and abuse detection and prevention;

l. Access and availability; and

m. Data collection, analysis, and reporting.

2.18.4 **Internal Staff**: The health plan shall designate a Quality Assessment and Improvement and Utilization Management Coordinator. Specifically, the Quality Assessment and Improvement and Utilization Management Coordinator must:

a. Be responsible for assisting the governing body and their designee in the process of continually developing, implementing, evaluating, and improving the written quality assessment and improvement program. The continuous improvement process shall include care delivery objectives, specific activities implemented from issues identified as a result of the on-going monitoring process, systems methodologies for continuous tracking of care delivery, and provider review. The process must include a focus on health outcomes and action plans for improvement of those outcomes.

b. Be responsible for the health plan's utilization management and quality assessment committee, assist the governing board in directing the development and implementation of the health plan's internal quality assessment and improvement program, and monitor the quality of care that members receive.

c. Review all potential quality of care problems, both physical and behavioral health, and oversee development and implementation of continuous assessment and improvement of the quality of care provided to members.

d. Ensure that health education resources are available for the provision of proper medical care to members.

e. Utilize staff in an effective and efficient manner to monitor and assess care delivery.

f. Specify clinical or health services areas to be monitored.

g. Specify the use of quality indicators that are objective, measurable, and based on current knowledge and clinical experience for priority areas selected by the state agency as well as for areas the health plan selects.

h. Ensure that all denied services are reviewed by a physician, physician assistant, or advanced nurse practitioner. The reason for the denial must be documented and logged. Any alternative services authorized must be documented. All denials must identify appeal rights of the member.

i. Monitor and report the following through the health plan's internal quality assessment and improvement process:

1) The management of the health plan's EPSDT program;

2) The health plan's referral process for specialty and out-of-network services;

3) The health plan's credentialing and recredentialing activities;

4) The health plan's process for prior authorizing and denying services;

5) The health plan's process for ensuring the confidentiality of medical records and member information;

6) The health plan's process for ensuring the confidentiality of the appointments, treatments, and required state agency reporting of adolescent STDs;

7) Monitor providers for compliance that reports of disease and conditions are made to the State Department of Health and Senior Services in accordance with all applicable State statutes, rules, guidelines, and policies and with all metropolitan ordinances and policies;

8) Monitor providers for compliance that control measures for tuberculosis, STDs, and communicable diseases are carried out in accordance with applicable laws and guidelines; and

9) The toll-free nurse hotline activities.

2.18.5 **Practice Guidelines**:

a. The health plan shall adopt practice guidelines that meet the following requirements:

1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

2) Consider the needs of the members;

3) Are adopted in consultation with contracting health care professionals;

4) Are reviewed and updated periodically as appropriate; and

5) Are disseminated to all affected providers, and upon request, to members and potential members.

b. The health plan shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines.

2.18.6 **Reporting**: In addition to internal monitoring of quality of care, the health plan shall submit reports to the state agency regarding the results of their internal monitoring, evaluation, and action plan implementation. The reports shall include targeted health indicators monitored by the state agency and specific quality data periodically requested by the Federal government. The reports will be in the format and frequency specified by the state agency located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/). The report format shall be periodically reviewed and updated by the state agency. The state agency shall provide the health plan with no less than ninety (90) calendar day's notice of any changes in the format requested. The health plan shall comply with all subsequent changes specified by the state agency.

a. The health plan shall participate in all data validation activities pertaining to such reports, as requested by the state agency.

2.18.7 **Monitoring**: The health plan shall provide access to documentation, medical records, premises, and staff as deemed necessary by the state agency. The health plan shall provide the state agency's independent external evaluators access to documentation, medical records, premises, and staff as deemed necessary by the state agency for the independent external review.

2.18.8 **Internal Procedures**: The health plan shall have an internal written quality assessment and improvement program procedures. The procedures shall include monitoring, assessment, evaluation, and improvement of the quality of care for all clinical and health service delivery areas. Emphasis should be placed on, but need not be limited to, clinical areas relating to maternity, pediatric and adolescent development, HCY/EPSDT, family planning, and well woman care, as well as on key access or other priority issues for members such as reducing the incidence of STDs, acquired immune deficiency syndrome, and tobacco related illnesses. The health plan shall implement mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. The health plan's quality review mechanisms shall address members with special needs as well as COA 1, COA 4, and COA 5 members in the written monitoring, assessment, evaluation, and improvement plan.

a. Internal policies and procedures shall:

1) Ensure that the utilization management and quality assessment committees have established operating parameters. The committees shall meet at least quarterly, on a regular schedule. Committee members must be clearly identified and representative of the health plan's providers. The committee shall be accountable to the Medical Director and governing body. The committees must maintain appropriate documentation of the committees' activities, findings, recommendations, actions, and follow-up.

2) Provide for regular utilization management and quality assessment reporting to the health plan management and health plan providers, including profiling of provider utilization patterns.

3) Be developed and implemented by professionals with adequate and appropriate experience in quality assessment and improvement: quality assessment, utilization management, and continuous improvement processes.

4) Provide for systematic data collection, analysis, and evaluation of performance and member results.

5) Provide for interpretation of this data to practitioners.

6) Provide timelines for correction, and assign a specific staff person to be responsible for ensuring compliance and follow-up.

7) Clearly define the roles, functions, and responsibilities of the quality assessment committee and the Medical Director.

b. Utilization Management: The health plan shall have and implement written utilization management policies and procedures that include protocols for denial of services, prior approval, hospital discharge planning, physician profiling, and concurrent, prospective, and retrospective review of claims that comply with Federal and State laws and regulations, as amended. The utilization management policies and procedures must be clearly specified in provider contracts or provider manuals and consistently applied in accordance with the established utilization management guidelines. As part of the health plan's utilization management function, the health plan shall also have processes to identify both over and under-utilization problems for inpatient and outpatient services, undertake corrective action, and follow-up. The health plan must monitor for the potential under-utilization of services by their members in order to assure that all covered services are being provided, as required. If any underutilized services are identified, the health plan must immediately investigate and correct the problem or problems which resulted in such underutilization of services. In addition, the health plan must conduct an ongoing review of service denials and must monitor utilization on an ongoing basis in order to identify services which may be underutilized. This review must consider the expected utilization of services regarding the characteristics and health care needs of the member population. In addition, the health plan shall use an emergency room log, or equivalent method, to track emergency room services (e.g. daily emergency room report from

targeted high volume facilities). Compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

c. Provider Credentialing: The health plan shall have written credentialing and re-credentialing policies and procedures for determining and assuring that all in-network providers are licensed by the State in which they practice and are qualified to perform their services. The health plan shall have written policies and procedures for monitoring the in-network providers, reporting the results of the monitoring process, and disciplining in-network providers found to be out-of-compliance with the health plan's medical management standards. The policies and procedures shall include the time frame in which the credentialing and re-credentialing must take place. The credentialing and re-credentialing process shall not take longer than sixty (60) business days pursuant to RSMo 376.1578. The health plan shall ensure providers are included in the network and eligible to receive payment immediately upon completion of the credentialing and re-credentialing process. The health plan shall use the Universal Credentialing Data Source Form (UCDS), pursuant to RSMo 354.442.1 (15) and 20 CSR 400.7.180, as amended. Following the effective date of the contract, the health plan shall provide the state agency with the Social Security Number of the providers. The health plan shall follow the requirements outlined in the Managed Care Policy Statements found in *MO HealthNet Managed Care Policy Statements* located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/).

1) As part of recredentialing, the health plan shall audit records of primary care providers, hospitals, home health agencies, personal care providers, and hospices to determine whether the provider is following the policies and procedures related to advance directives.

BAFO 001 REVISED THE FOLLOWING PARAGRAPH:

2) As part of credentialing and re-credentialing, the health plan shall collect from providers directly contracted with the health plan, full and complete information, as described herein, regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, CHIP, or any other Federal health care program, including Public Chapter 379 of the Acts of 1999 and 42 CFR 455.104-106 and 42 CFR 1001.1001-1051. The health plan shall collect and provide this information to the state agency in the format and frequency specified by the state agency in "*Ownership or Controlling Interest Disclosure", "Transaction Disclosure"*, and "*Provider and Subcontractor Disclosure"* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

- At the stage of provider credentialing and re-credentialing;
- Upon execution of the provider agreement;
- Within thirty-five (35) days of any change in ownership of the provider; and
- At any time upon the request of the state agency for any or all of the information described in this section.

3) The health plan shall promptly forward such disclosures to the state agency, in accordance with prescribed timeframes. Per the subcontracting requirements specified herein, the health plan shall include provisions in its subcontracts for health care services notifying the provider or benefit management organization to provide the disclosures to the health plan. The state agency will, in accordance with 42 CFR 455.106(b), notify the HHS Office of the Inspector General (HHS-OIG) within twenty (20) business days from the date it receives the information, of any disclosures made by providers under 42 CFR 455.106 (relating to criminal convictions of the provider, or of a person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider).

BAFO 001 REVISED THE FOLLOWING PARAGRAPH:

4) The health plan shall promptly notify the state agency of any denial of provider credentialing or re-credentialing. This requirement is in addition to the requirement herein for the health plan to report provider terminations as part of its quarterly fraud, waste, and abuse report. The state agency shall, pursuant to 42 CFR 1002.3(b), promptly notify HHS-OIG of the denial of credentialing or re-credentialing where that denial is based on a determination that the provider has been excluded from participation in Medicare, Medicaid, CHIP, or any other Federal health care program; has failed to renew its license or certification registration, or has a revoked professional license or certification; has been terminated by the state agency; or has been excluded by OIG under 42 CFR 1001.1001 or 1001.1051. In making such disclosures, the health plan shall use the template provided in *Provider and Subcontractor Disclosure* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

BAFO 001 ADDED THE FOLLOWING PARAGRAPH:

5) As part of credentialing and re-credentialing, the health plan shall screen all health care service subcontractors to determine whether the subcontractor or any of its employees or subcontractors has been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care program (as defined in Section 1128B(f) of the Act); has failed to renew license or certification registration; has revoked professional license or certification; or has been terminated by the state agency. The screening shall consist of, at a minimum, consulting the following databases on at least a monthly basis: the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS). The LEIE is located at https://oig.hhs.gov/exclusions/exclusions_list.asp and the EPLS is located at https://www.sam.gov/portal/public/SAM/. The screening shall also consist of consulting the following additional databases, consistent with State and Federal requirements: the National Plan and Provider Enumeration System (NPPES), located online at https://nppes.cms.hhs.gov/NPPES/Welcome.do, the Missouri Professional Registration Boards website, and any such other State or Federal required databases. The health plan may use the template provided in *Provider and Subcontractor Disclosure* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/) to memorialize these screenings. The health plan shall deny credentialing or re-credentialing to any subcontractor that falls within this section. In addition, the health plan shall terminate the provider contract of any subcontractor for which a check reveals that the subcontractor falls within this section.

d. Performance Improvement Projects: The health plan shall conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. As requested, the health plan shall report the status and result*s* annually of one clinical and one non-clinical performance improvement project to the state agency.

1) The performance improvement projects shall involve the following:

- Measurement of performance using objective quality indicators;
- Implementation of system interventions to achieve improvement in quality;
- Evaluation of the effectiveness of the interventions;
- Planning and initiation of activities for increasing or sustaining improvement;

- Completion of the performance improvement project in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year; and

- Performance measures and topics for performance improvement projects specified by the state agency in consultation with other stakeholders.

2) Statewide Performance Improvement Project(s): The health plan shall participate in a statewide performance improvement project(s) as specified by the state agency. A statewide performance improvement project(s) is defined as a cooperative quality improvement effort by the health plan, the state agency, and the external quality review organization (EQRO) to address clinical or non-clinical topic areas relevant to the Managed Care Program. The statewide performance improvement project(s) shall be designed to identify, develop, and implement standardized measures and statewide interventions to optimize health outcomes for the members and improve efficiencies related to health care service delivery.

The current statewide performance improvement project is Improving Oral Health. In addition to the Improving Oral Health performance improvement project, the health plan shall implement a performance improvement project to attain a target rate of ninety percent (90%) for the number of two (2) year olds immunized during the first year of the contract.

2.18.9 **Accreditation**:

a. The health plan shall obtain health plan accreditation, at a level of "accredited" or better, for the MO HealthNet product from NCQA within twenty-four (24) months of the first day of the effective date of the contract. The health plan shall maintain such accreditation thereafter and throughout the duration of the contract.

b. If the health plan is new to MO HealthNet Managed Care, the health plan shall obtain accreditation, at a level of "accredited" or better, for the MO HealthNet product from NCQA within thirty (30) months following the effective date of the contract. The health plan shall file its application within ninety (90) days of the effective date of the contract. Failure to obtain accreditation at a level of "accredited" or better within this timeframe and failure to maintain accreditation thereafter shall be considered a breach of the contract and shall result in termination of the contract in accordance with the terms set forth herein. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of the final NCQA report and may result in termination of the contract in accordance with the terms and conditions set forth herein.

c. In order to ensure that the health plan is making forward progress, the health plan shall provide to the state agency the following information at the following times:

1) Status update to include, at a minimum, the proof of application and all supporting documents six (6) months after the first day of the effective date of the contract; and

2) Status update to include, at a minimum, the projected date for the on-site reviews twelve (12) months after the first day of the effective date of the contract.

d. If the health plan fails to meet the applicable requirements stated above, the health plan shall be considered to be in breach of the terms of the contract and may be subject to remedies for violation, breach, or non-compliance of contract requirements as described herein.

2.19 Community Health Initiatives:

2.19.1 The health plan shall participate in community health improvement initiatives along with local public health agencies that align with the Maternal Child Health Program (MCH), Department of Health and

Senior Services (DHSS) strategic priorities. DHSS will provide their strategic priorities and a list of corresponding best practices for MCH health improvement initiatives to the health plans. DHSS, MCH/Center for Local Public Health Services shall provide technical assistance to link the health plan to health improvement initiatives being conducted at a local level. The health plan shall participate in health improvement initiatives by, at a minimum:

a. Becoming a member of a regional and/or community-wide MCH planning coalition. Community means a geographic entity (usually a county (ies) with broad based representation from local public health agencies, community providers, businesses, local organizations, schools, etc. DHSS will provide information to the health plans about DHSS/MCH strategic priorities. The health plan shall not be required to be the lead agency in establishing a coalition.

b. Being actively involved in the development and implementation of the community strategic plan to implement health improvement programs.

c. Providing feedback on the community strategic plan and its effectiveness.

2.20 State and Federal Reviews:

2.20.1 **General**: The health plan shall make available to the state agency or its outside reviewers, on an annual basis and on an as needed basis, medical and other records for review of quality of care, access, financial, and other issues and shall cooperate fully in any associated reviews or investigations. The state agency's quality assessment and improvement review may include but is not limited to:

a. On-site visits and inspections of facilities;

b. Staff and member interviews;

c. Review of utilization, denial of services, and other areas that will indicate quality of care delivered to members;

d. Medical records reviews;

e. Financial records reviews;

f. Review of all quality assessment procedures, reports, committee activities and recommendations, and corrective actions;

g. Review of staff and provider qualifications;

h. Review of the complaint, grievance, and appeal process and resolutions;

i. Review of requests for transfers between primary care providers within each health plan;

j. Review of fraud, waste, and abuse detection, prevention, and review process, procedures, cases, and reports; and

k. Evaluation and analysis of coordination and continuity of care.

2.20.2 **Service Validation**: The health plan shall make available full detailed claims data to the Department of Social Services and the state agency's designated Recovery Audit contractor(s) for the purpose of validation of services rendered and determination of proper payments.

2.20.3 **External Reviews**: The state agency contracts with independent external evaluators to examine the quality of care provided by the health plans. CMS designates an outside review agency to conduct an

evaluation of the program and its progress toward achieving program goals. The health plan shall make available to CMS's outside review agency and the state agency's external evaluator medical and other records for review as requested. The health plan shall provide information for External Quality Reviews in the format specified by the state agency.

2.21 Financial Reporting

2.21.1 **Financial Data Reporting**: The health plan shall submit unaudited, semi-annual reports and an audited, annual report for their MO HealthNet Managed Care book of business to the state agency's contracted actuary. The health plan shall submit the semi-annual and annual reports in the format and in accordance with the audit guidelines specified by the state agency's contracted actuary. A sample of the report format and audit guidelines can be found at *Health Plan Financial Reporting Form* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/). Changes to the report format must be approved by the state agency's contracted actuary prior to submission.

a. The unaudited, semi-annual and audited annual reports must be certified by one of the following:

   1) The health plan's Chief Executive Officer;

   2) The health plan's Chief Financial Officer; or

   3) An individual who has delegated authority to sign for, and who reports directly to, the health plan's Chief Executive Officer or Chief Financial Officer.

b. The certification must attest, based on best knowledge, information, and belief, as follows:

   1) To the accuracy, completeness, and truthfulness of the data; and

   2) 2) To the accuracy, completeness, and truthfulness of the semi-annual and annual reports.

c. The health plan shall submit the certification concurrently with the semi-annual and annual reports.

2.21.2 **Physician Incentive Plan Reports**: On an annual basis and in compliance with the Federal regulation, the health plan shall disclose physician incentive plans to CMS and the state agency. The disclosure statement shall include the following:

a. Whether services furnished by the physician or physician group are covered by the physician incentive plan. No further disclosure shall be required if the physician incentive plan does not cover services furnished by the physician or physician group in question;

b. Effective date of the physician incentive plans;

c. The type of incentive arrangement;

d. The percent of withhold or bonus applied, if applicable;

e. If the physician or physician group is at substantial financial risk, proof that the physician or physician group has adequate stop-loss coverage;

f. The amount and type of stop-loss protection;

g. The patient panel size;

h. If pooled, a description of the approved method;

i. The computations of significant financial risk; and

j. Name, address, telephone number, and other contact information for a person from the health plan who may be contacted with questions regarding the physician incentive plans.

2.21.3 **Third Party Savings Report**: The health plan shall provide quarterly reports to the state agency detailing third party savings in a format and frequency specified by the state agency in the *Third Party Savings Reports* and *Third Party Savings Reports Instructions* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/). The health plan shall maintain records in such a manner as to ensure that all money collected from third party resources may be identified on behalf of members. The health plan shall make these records available for audit and review and certify that all third party collections are identified and used as a source of revenue.

BAFO 001 REVISED THE FOLLOWING PARAGRAPH:

2.21.4 **Ownership and Financial Disclosure**: The health plan shall update ownership and financial disclosure information on an annual basis. The information shall be provided to the state agency within thirty-five (35) days of a written request. This report shall include full and complete information regarding ownership, financial transactions, and persons as described herein. The report shall be submitted in the format specified by the state agency in the "*Ownership or Controlling Interest Disclosure"* and *"Transaction Disclosure"* located on the MO HealthNet Division website at *Health Plan Reporting Schedule and Templates (*http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

2.21.5 **Financial Transparency and Analysis**: Upon request from the state agency, the health plan shall submit provider (for all types, e.g. physicians, clinics, hospitals, etc.) specific payment data in the format and for the time-period specified by the state agency.

a. The health plan shall provide a copy of all administrative services contracts and management agreements (including financial terms) delegating administrative functions to a third party, including related or affiliated parties. In addition, the health plan shall provide all contracts with related or affiliated parties applicable during any part of a state fiscal year, the total cost of providing the service and the amount charged to the MO HealthNet programs.

This should include, but not be limited to, the following:

1) Management service agreements;
2) Delegated case management/disease management agreements;
3) Delegated member/provider services agreements;
4) Claims processing agreements;
5) Integrated delivery system agreements; or
6) Any other contract with a related or affiliated party for non-medical services or charges.

b. The health plan shall keep copies of all of these requests and responses to them, make them available upon request, and advise the state agency when there is no response to a request.

BAFO 001 REVISED THE FOLLOWING PARAGRAPH:

c. The health plan shall submit this information semi-annually with the semi-annual reporting of the unaudited Health Plan Financial Reporting Form for the periods covered in the financial reporting form submission. The health plan must send the information directly to the state agency's contracted actuary and shall indicate the extent to which such information shall be held confidential under RSMo 610.21.

2.22 Operational Data Reporting:

2.22.1 The health plan shall provide the state agency with information concerning uniform utilization, quality assessment and improvement, member satisfaction, complaint, grievance, and appeal, fraud, waste, and abuse detection, and behavioral health data on a regular basis. On a periodic basis, the health plan shall make available clinical outcome data in areas of concern to the state agency, to include, but not be limited to behavioral health data. The health plan shall cooperate with the state agency in carrying out data validation steps.

2.22.2 **Presentation of Findings**: The health plan shall obtain the state agency's approval prior to publishing or making formal public presentations of statistical or analytical material based on the health plan's membership.

2.22.3 **Call Center Report**: The health plan shall submit reports on the activities of all call center/hotlines required herein in the format and frequency specified by the state agency in: *Call Center Report* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

2.22.4 **Case Management Reports**: The health plan shall provide quarterly reports analyzing and evaluating its case management program using the format and frequency specified by the state agency:

a. *Case Management Log* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

b. *Behavioral Health Case Management Survey Instructions* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

2.22.5 **Complaint, Grievance, and Appeal Reports**: The health plan shall submit to the state agency a report, for both member and provider complaints, grievances, and appeals in the format and frequency specified by the state agency in the *Complaint, Grievance, and Appeal Report* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

2.22.6 **Disease Management Report**: The health plan shall submit to the state agency a report that includes the total number of members enrolled and disenrolled during the designated time period. The report shall be submitted in the format and frequency specified by the state agency in the *Disease Management Report* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

2.22.7 **Federally Qualified Health Center and Rural Health Clinic Reporting**:

a. The health plan shall submit Schedule M-1 and Schedule M-2 in the format and frequency as specified by the state agency in the *Federally Qualified Health Center and Rural Health Clinic M-1 Instructions and Forms* and/or *Federally Qualified Health Center and Rural Health Clinic M-2 Instructions and Forms* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

b. The health plan shall submit a list of the health plan's in-network FQHCs, RHCs, and CMHCs to the state agency annually upon request. Please see Exhibit C and *Federally Qualified Health Centers, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Local Public Health Agencies and Family Planning and STD Providers* located on the MO HealthNet website at Health

Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

2.22.8 **Fraud, Waste, and Abuse Activities Reports**: The health plan shall provide a quarterly report of fraud, waste, and abuse activities to the state agency. The report must be submitted in accordance with state agency guidelines contained within the fraud, waste, and abuse policy statement, and in the format and frequency specified by the state agency in the *Fraud, Waste, and Abuse Activities Report* instructions located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (/dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates).

2.22.9 **Healthcare Quality Data**: The health plan shall submit reports of healthcare quality data (physical and behavioral) in the format and frequency required by the state agency in the *Healthcare Quality Data Template* and the *Healthcare Quality Data Instructions* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates **(**http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/**).** The health plan shall ensure use of the correct technical specifications and template for each reporting period.

2.22.10 **Lead Poisoning Prevention**: The health plan shall submit to the state agency a report on lead poisoning prevention in the format and frequency specified by the state agency in the *Lead Poisoning Prevention Report* instructions located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

2.22.11 **Marketing and Education Materials Verification**: The health plan shall provide the state agency with documentation verifying the health plan reviewed its education and marketing materials and acted upon any required changes annually by October 1st.

2.22.12 **Provider Network Reports**:

a. The annual access plan as required by the Missouri Department of Insurance, Financial Institutions & Professional Registration (DIFP). Information on these reports is available at http://insurance.mo.gov/industry/filings/mc/accessMain.php. In the event the health plan attains accreditation, the health plan shall continue to submit network files and the access plan as outlined in DIFP regulations.

b. In addition, the health plan shall update the provider network file at the time of any change and as required in the Health Plan Record Layout Manual available at http://manuals.momed.com/edb_pdf/Health%20Plan%20Record%20Layout%20Manual.pdf.

2.22.13 **Quality Assessment and Improvement Evaluation Reports**:

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

a. Periodic Reports of Quality and Utilization: The health plan shall provide periodic reports regarding case management, quality initiatives, and other quality analysis reports per request of the state agency. When requested by the state agency, these reports must be submitted to the state agency reporting website at MHD.MCReporting@dss.mo.gov. In addition, the health plan shall provide the following reports:

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

1) HEDIS Measures: The health plan shall submit the HEDIS measures to the Department of Health and Senior Services (DHSS) in accordance with 19 CSR 10-5.010 as amended. Any changes to the list of specific HEDIS measures to be submitted shall be provided to the health plan by the state agency no later than December 31 prior to the measurement year. Additionally, the health plan shall submit these measures to the state agency on the annual *Healthcare Quality Data Template* located on the MO HealthNet website at Health Plan

Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

2) The health plan shall submit to the state agency the HEDIS certified results for the following HEDIS measures for each region: Follow-up After Hospitalization for Mental Disorders (FUH); Prenatal and Postpartum Care (PPC); Well Child Visits in the First 15 Months of Life (W15); Well Child Visits in the Third, Fourth, Fifth and Sixth Year of Life (W34); Ambulatory Care (AMB); Mental Health Utilization (MPT) and Identification of Alcohol and Other Drug Services (IAD). Results shall be reported to the state agency on the annual *Healthcare Quality Data Template* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

3) The health plan shall submit to the state agency the HEDIS certified results on measures required annually by NCQA for health plan accreditation and continued accreditation. Results shall be reported to the state agency on the annual *Healthcare Quality Data Template* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

4) Member Satisfaction Data/Report (CAHPS): The health plan shall submit the Consumer Assessment of Health Plans Study (CAHPS) Questionnaire applicable for the reporting year pursuant to 19 CSR 10-5.010, as amended, and NCQA requirements. Pursuant to CHIPRA requirements, a separate sampling frame must be generated for children in CHIP and Medicaid/non-CHIP programs on the survey provided to the DHSS. The health plan shall fund the cost of the survey. The health plan shall use the survey instrument specified by the DHSS for reporting to DHSS. The health plan shall submit to the state agency the raw CAHPS data results and the NCQA HEDIS CAHPS Data Submission Summary Tables. The raw data and the submitted Summary Tables shall clearly distinguish results for six separate samples: three regions (Eastern, Central, and Western) and two member groups per region (CHIP and Medicaid/non-CHIP). The template will be provided upon contract award.

b. Annual Quality Assessment and Improvement (QA & I) Evaluation Report. The health plan shall submit an annual quality assessment improvement evaluation report in a format and frequency specified by the state agency in the *Quality Assessment and Improvement Evaluation Report* and *Quality Assessment and Improvement Evaluation Instructions* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

2.22.14 **Special Health Care Needs Report**: The health plan shall submit to the state agency a report of special needs in the format and frequency specified by the state agency in the *Special Health Care Needs Report* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

2.22.15 **Subcontractor Oversight Reports**: The health plan shall submit an annual subcontractor oversight report that reflects the health plan's monitoring activities in the previous year for each health care service subcontractor and any corrective actions implemented as a result of its monitoring activities. The annual subcontractor oversight reports shall be submitted in the format and frequency specified by the state agency at the *Subcontractor Oversight Annual Evaluation Report* located on the MO HealthNet website in the Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

2.22.16 **Suspected Fraud, Waste, or Abuse Reports**: The health plan shall provide quarterly reports of suspected fraud, waste, or abuse cases to the state agency using the format and frequency specified by the state agency in the *Fraud, Waste or Abuse Activities Report* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

2.22.17 **Timeliness of Claim Adjudication Report**: On a quarterly basis, the health plan shall submit to the state agency a report in the format and frequency specified by the state agency in *Timeliness of Claims Adjudication Report* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

2.23 Third Party Liability:

2.23.1 Third Party Liability is defined as any individual, entity, or program that is or may be liable to pay all or part of the health care expenses of a Medicaid beneficiary. Under Section 1902(a) (25) of the Act, the State is required to take all reasonable measures to identify legally liable third parties and treat third party liability as a resource of the Medicaid beneficiary.

AMENDMENT 1 DELETED THE FOLLOWING PARAGRAPH:

a. DELETED

AMENDMENT 1 DELETED THE FOLLOWING PARAGRAPH:

b. DELETED

2.23.2 **Coordination of Benefits**: By law, the state agency is the payer of last resort. Therefore, the health plan shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The two methods used in the coordination of benefits are cost avoidance and post-payment recovery (i.e., "pay and chase "). The health plan shall act as an agent of the state agency for the purpose of coordination of benefits.

AMENDMENT 1 INSERTED THE FOLLOWING PARAGRAPH AND RENUMBERED ALL SUBSEQUENT PARAGRAPHS:

a. The health plan must provide labor, delivery, and postpartum care; prenatal care for pregnant women; preventive pediatric services; and services that are provided to a Managed Care member on whose behalf a child support enforcement order is in effect. If a third party liability payor exists for these services, the provider may bill the third party liability payor. If the claim for payment is submitted to the health plan, the health plan shall make payment and seek reimbursement from the third party liability payor (pay and chase).

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

b. If the health plan has established the probable existence of liability of a third party health insurance carrier at the time a claim is filed, the health plan shall reject the claim and return it to the provider for a determination of the amount of liability except in certain defined situations referenced below. This rejection is called *cost avoidance*. If a service is medically necessary, the health plan shall ensure that its cost avoidance efforts do not prevent a member from receiving such service and that the member is not required to pay any cost-sharing for use of the other insurer's providers.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

c. The establishment of liability takes place when the health plan receives confirmation from the provider or the third party health insurance carrier indicating the extent of liability. If the probable existence of a liable third party cannot be established or third party benefits are not available to pay the member's medical expenses at the time the claim is filed, the health plan shall pay the full amount allowed under the health plan's payment schedule. When the amount of liability is

determined, the health plan shall pay the claim to the extent that payment allowed under the health plan's payment schedule exceeds the amount of the third party health insurance carrier's payment.

1) If a third party health insurance carrier (other than Medicare) requires the member to pay any cost-sharing (such as copayment, coinsurance, or deductible), the health plan is responsible only for the difference between the Medicaid allowable amount and the payment received from the third party health insurance carrier. If the health plan's subcontractor has negotiated a rate less than the Medicaid allowable amount with the third party carrier, the health plan has the option of paying the member's remaining cost-sharing amount if the health plan has included that provision in the contract with their subcontractor. At no time is the member responsible for any cost-sharing amounts.

2) The health plan's responsibility under subparagraph (1) applies even if services were provided by an out-of-network provider. The health plan may require prior authorization of out-of-network services. The out-of-network provider must agree in writing to accept the amount of the health plan's payment as payment in full prior to the service being provided. If the out-of-network provider does not agree to accept the health plan's payment as payment in full, the health plan shall inform the member verbally and in writing that, due to lack of such agreement, the member will be liable for cost sharing or balance billing amounts to the out-of-network provider, but the member may instead seek services without charge from an in-network provider.

3) For additional clarity on establishment of the health plan's liability, the following examples are provided:

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

- The provider received $75.00 from the third party insurance carrier. A provider submits a charge for $100.00 to the health plan for which the Medicaid allowable is $80.00. There is no agreement between the provider and third party insurance carrier that the amount paid by the carrier is payment in full. The provider normally bills all patients with this carrier the remaining balance of $25.00. The provider would submit a claim to the health plan indicating the remaining balance of $25.00 is owed after receiving $75.00 from the third party carrier. The amount the health plan pays the provider is the difference between the Medicaid allowable ($80) and the carrier's payment ($75.00) or $5.00.

- A provider has a charge of $100.00 for a service for which the Medicaid allowable amount is $80.00. The provider has agreed to accept the third party carrier's payment as payment in full with the exception of any cost-sharing. The carrier has an allowable of $50.00 with the remaining $25.00 to be a contractual write-off. The member's cost-sharing amount is $25.00. The provider normally bills all patients with this carrier only the cost-sharing amount ($25.00). The provider receives $50.00 from the third party carrier and submits a claim to the health plan in the amount of $50.00. The health plan may pay the difference ($30.00) between the Medicaid allowable amount ($80.00) and the third party carrier's payment ($50.00) or the health plan may choose to pay only the member's cost-sharing amount ($25.00), if the health plan has included that provision in the contract with their subcontractor.

- An out-of-network provider has a charge of $100.00 for a service for which the Medicaid allowable amount is $80.00 and the payment from the third party carrier is $50.00. The out-of-network provider does not agree in writing to accept the difference ($30.00) between the Medicaid allowable amount ($80.00) and the third party carrier's payment ($50.00) as payment in full prior to the service being provided. The health plan shall inform the member, verbally and in writing, that due to lack of such agreement, the member will be liable for the difference ($50.00) between the provider's charge ($100.00) and the payment from the third party carrier ($50.00). If the member chooses to receive the service from the

out-of-network provider, the member is responsible for the difference ($50.00) between the provider's charge ($100.00) and the payment from the third party carrier ($50.00). The member may instead seek services without charge from an in-network provider. The health plan pays nothing to the out-of-network provider.

- The health plan must provide labor, delivery, and postpartum care; prenatal care for pregnant women; preventive pediatric services; and services that are provided to a Managed Care member on whose behalf a child support enforcement order is in effect. If a third party payer exists, and there is a third party payer indicator on the eligibility file for the member, the health plan may cost avoid the claim for the preventive services referenced above. If there is not a third party payer indicator on the eligibility file for the member, the health plan must pay the claim. If there is not a third party payer indicator on the eligibility file for the member, but the health plan believes a third party payer exists, the health plan must pay and chase the claim.

- Federal Law, Section 2713 of the Public Health Act requires non-grandfathered health plans to provide, at a minimum, coverage without cost-sharing for preventive services rated 'A' or 'B' by the U.S. Preventive Services Force (http://www.uspreventiveservicestaskforce.org). If these services are provided to members, the same coordination of benefits referenced above should be followed.

d. The health plan may retain up to one-hundred percent (100%) of its third party collections if all of the following conditions exist:

1) Total collections received do not exceed the total amount of the health plan's financial liability for the member;

2) There are no payments made by the state agency related to fee-for-service; and

3) Such recovery is not prohibited by Federal or State law.

e. The state agency shall provide the health plan with a daily file of third party health insurance carrier information (other than Medicare) for the purpose of updating the health plan's files. The state agency shall continue to perform verification of the health insurance information. The state agency does not warrant that the information is complete or accurate. The file is to be considered a "lead" file to assist the health plan in identifying legally liable third parties. The health plan shall timely notify the state agency of any known changes, additions, or deletions of coverage in a format prescribed by the state agency.

f. The state agency shall annually perform a data match with the United States Department of Defense to identify members covered by TRICARE. The state agency shall provide the health plan with the results of the data match annually and in a format specified by the state agency. The health plan shall perform post-payment recovery and cost avoidance activities as appropriate based on the information supplied by the data match.

2.23.3 **Casualty/Tort**: The health plan shall act as an agent of the state agency for purposes of third party reimbursement pursuant to RSMo 208.215, as amended. In addition to coordination of benefits, the health plan shall pursue reimbursement in the following circumstances: Workers' Compensation, Tortfeasors, Motorist Insurance, and Liability/Casualty Insurance.

a. The health plan shall take action to identify those paid claims for members that contain diagnosis codes 800 through 999 (ICD 9-CM), with the exception of 994.6, for the purpose of determining the legal liability of third parties so that the health plan may process claims under the third party liability payment procedures specified in 42 CFR 433.139 (b) through (f), as amended.

b. The state agency shall perform a data match with the Department of Labor, Division of Workers' Compensation to identify members that the Division of Workers' Compensation has a record of a work-related injury claim. The state agency shall provide the health plan with the results of the data match monthly and in a format specified by the state agency. The health plan shall perform post payment recovery and cost avoidance activities as appropriate based on the information supplied by the data match. If the probable existence of third party liability cannot be established or third party benefits are not available to pay the member's medical expenses at the time the claim is filed, the health plan shall pay the full amount allowed under the health plan's payment schedule.

c. The state agency shall perform a data match with the State Traffic Accident Reporting System (STARS) of the Missouri Highway Patrol to identify members that the STARS system has a record of a member involved in a motor vehicle accident. The state agency shall provide the health plan with the results of the match monthly and in a format specified by the state agency. The health plan shall perform further validation activities when using information supplied by the data match to ensure the member is in fact the person referenced in the match. If the probable existence of third party liability cannot be established or third party benefits are not available to pay the member's medical expenses at the time the claim is filed, the health plan shall pay the full amount allowed under the health plan's payment schedule.

d. The health plan shall perform all research, investigations, and payment of lien-related costs, including but not limited to, attorney fees and costs related to such cases.

e. If a member initiates a legal action as a result of an injury that occurred during the term of the contract, the health plan may file a lien for reimbursement for medical services provided to treat the injury that occurred during the term of the contract even after the contract has ended.

f. If the health plan initiates a lien during the term of the contract but the case remains unsettled at the end of the contract, the health plan may continue pursuit of the action for the medical services related to the injury that were provided during the term of the contract.

g. If the member enrolls with a new health plan while legal action is pending, each health plan may file separate liens to recover reimbursement for medical services related to the injury that were provided during the respective contract periods.

2.24 Reinsurance: The state agency will not administer a reinsurance program funded from capitation payment withholdings.

2.25 Reserving: As part of its accounting and budgeting function, the health plan shall establish an actuarially sound process for estimating and tracking incurred but not reported costs. The health plan shall reserve funds by major categories of service (e.g., hospital inpatient; hospital outpatient) to cover both incurred but not reported, and reported but unpaid claims. As part of its reserving methodology, the health plan shall conduct annual reviews to assess its reserving methodology and make adjustments as necessary.

2.26 Claims Processing and Management Information Systems:

2.26.1 **General Requirements**: The health plan shall have a Claims Processing and Management Information System (MIS) capable of meeting the MO HealthNet managed care program requirements and maintaining satisfactory performance throughout the term of the contract. The health plan shall have the capability to transmit and receive data, support provider payments, and comply with data reporting requirements as specified herein. The health plan shall have the capability to process claims, retrieve and integrate enrollment data, assign primary care providers, maintain provider network data, and submit encounter data. The Claims Processing and MIS should be of sufficient capacity to expand as needed due to member enrollment or program changes.

2.26.2 **Resource Availability for Systems Changes**: The health plan shall employ or have available, the resources necessary to make modifications to claims processing edits or expansion of MIS capabilities as a result of changes in MO HealthNet Managed Care policies and/or procedures. The state agency will make every effort to give the health plan sixty (60) calendar days' notice of changes in the MO HealthNet Managed Care Program that may require the health plan to make system changes in order to comply.

2.26.3 **Electronic Claims Management (ECM) Functionality**: The health plan shall have in place an electronic claims management (ECM) capability that accepts and processes claims submitted electronically with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent forms, certification for medical necessity for abortion, necessary operative reports, etc.). As part of this ECM function, the health plan shall also provide on-line and phone-based capabilities to obtain claims processing status information and shall support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

2.26.4 **Adherence to Key Health Care Transaction Standards**: The health plan shall adhere to the Health Insurance Portability and Accountability Act (HIPAA) national standards related to claims processing. These shall include, but not be limited to, electronic transactions standards, federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19, and RSMo 376.383 and 376.384.

Section 1104 of the Patient Protection and Affordable Care Act mandated the implementation of operating rules that complement the HIPAA mandated standards and health plan certification of compliance. The health plan shall adhere to all federally required Council for Affordable Quality Healthcare's Committee on Operating Rules for Information Exchange (CAQH CORE) Operating Rule Sets. These shall include, but not be limited to, 45 CFR Parts 160 and 162 (CMS–0032–IFC) Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions and 45 CFR Parts 160 and 162 (CMS-0024-IFC) Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice. To meet federal requirements, the health plan will file a statement with HHS certifying that they are in compliance with the standards and operating rules.

2.26.5 **Encounter Data and Transactions**:

a. The state agency collects and uses encounter data for many purposes such as federal reporting, rate setting and risk adjustment, payment indication of Delivery and NICU supplemental payments, services verification, managed care quality improvement activities, utilization patterns and access to care, hospital rate setting, and research studies.

b. The health plan must void encounter claims when the health plan discovers that the data are incorrect, no longer valid, or some element of the claims not identified as part of the original claim needs to be changed except as noted otherwise. The health plan health plan shall void encounter claims if the state agency discovers errors or conflicts with a previously adjudicated encounter claim within thirty (30) calendar days of being notified by the state of such errors or conflicts.

c. The health plan's encounter data submissions will be assessed for completeness. The health plan is responsible for collecting information from providers and reporting the data to the state agency. As with data completeness, the health plan is responsible for assuring the collection and submission of accurate data to the state agency.

1) The health plan shall maintain at least a ninety-eight percent (98%) submission rate of all encounters with an overall encounter acceptance rate of ninety-eight percent (98%) as measured by the state agency.

2) The health plan shall submit encounter data for all services provided including those services that are reimbursed by the health plan through a capitated arrangement or other subcontracted arrangement. Encounters not submitted for these types of arrangements may result in a corrective action plan for the health plan.

d. As part of the 1996 HIPAA Title II Act-Administrative Simplification Standards 2009 Modifications, all HIPAA-covered entities are required to implement the Version 5010 transaction set. The transaction standards rule 45 CFR Part 162 [CMS-0009-F] published on January 16, 2009 mandates the use of the Accredited Standards Committee X12 (X12) version 5010 for health care. As new sets of HIPAA electronic transaction standards are adopted, the health plan must transition to the new standards by the date specified by the State, which will be no earlier than the federal compliance date. The state agency will establish requirements specific to MO HealthNet business needs for the transactions used by the health plans to submit the encounter or other data in the message formats detailed below. Any deviations from the HIPAA transaction standards will be specified in the state agency Companion Guide and communicated to the health plan. The health plan must submit the encounter and other data in the format specified by the state agency.

Claim Transactions:
- 837P – Professional
- 837I – Institutional
- 837D – Dental

Remittance Advice
- 835

Eligibility Inquiry and Response
- 270/271

Claim Status Inquiry and Response
- 276/277

Group Premium Payment for Insurance Products
- 820

Benefit Enrollment and Maintenance - Change Transactions (Enrollments, Disenrollments and ME Code Changes): The health plan shall accept and process this daily file in accordance with the required specifications as referenced in subsection b of this section.
- 834

ASC X12 Standard Acknowledgement
- 997
- 999

Compliancy standards shall be enforced in accordance with the state agency's Companion Guides for each transaction. Companion Guides are available via the Internet at the state agency's website: http://www.dss.mo.gov/mhd/providers/index.htm (Look under HIPAA - EDI Companion Guide).

e. The health plan shall transmit encounter data files at least monthly, and in accordance with any applicable CMS requirements related to the appropriate versions of the Implementation Guide or Missouri's Companion Guide. The State of Missouri will establish the requirements for submitting provider data on encounter claims. The performing provider's national provider identifier (NPI) is required on all encounter submissions.

f. 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 plan's applicable reimbursement methodology for that service.

g. Encounters must be submitted within 30 days of the day the health plan pays the claim and must be received no later than two (2) years from the first date of service.

h. The encounter data must be certified by one of the following:

1) The health plan's Chief Executive Officer;

2) The health plan's Chief Financial Officer; or

3) An individual who has delegated authority to sign for, and who reports directly to, the health plan's Chief Executive Officer or Chief Financial Officer.

i. The certification must attest, based on best knowledge, information, and belief, as to the accuracy, completeness, and truthfulness of the encounter data.

j. The health plan shall submit the certification concurrently with the encounter data.

k. The health plan shall provide encounter data for the External Quality Reviews in the format specified by the state agency.

l. The performing provider's national provider identifier (NPI) is required on all encounter submissions where the provider is required to have an NPI. The health plan shall submit the NPI on all encounter claim provider fields where the NPI is required. Otherwise, the health plan shall submit the provider's unique health plan assigned identifier on all encounter claim provider fields. The health plan shall submit the NPI with the corresponding unique health plan assigned provider identifier in the provider demographics file.

BAFO 001 DELETED THE FOLLOWING PARAGRAPH:

m. DELETED

2.26.6 **International Classification of Diseases (ICD-10)**: As part of the 1996 HIPAA Title II Act – Administrative Simplification Standards 2009 Modifications, all HIPAA-covered entities are required to implement the standard medical data code sets for coding diagnoses and inpatient hospital procedures by concurrently adopting the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding. The medical data code set standards rule 45 CFR Part 162 [CMS-0013-F] published on January 16, 2009 mandates the use of the ICD-10-CM and ICD-10-PCS medical data code sets. These new codes replace the current International Classification, 9th Revision, Clinical Modification, Volumes 1 and 2 and the International Classification, 9th Revision, Clinical Modification, Volume 3 for diagnosis and procedure codes respectively. The State of Missouri will enforce the health plan's compliance for all electronic exchanges of encounter or other data effective the date mandated by CMS in Federal regulation for implementation of the ICD-10 code set by covered entities.

2.26.7 **Other Electronic Data Exchange**:

a. Provider Demographic File: The health plan shall transmit through the provider demographic file, all primary care provider assignments, all changes, additions and deletions for all providers, and include a stop date. In accordance with the Health Plan Record Layout Manual, the health plan shall submit all required fields including the NPI and taxonomy if available.

b. PCP Assignment File

c. TPL Lead File

d. HBM Baseline Health Data File.

2.26.8 **Information Systems Availability**: The health plan shall ensure that critical member and provider Internet and/or telephone-based functions and information, including but not limited to ECM and self-service customer service 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 the state agency and the health plan. The health plan shall ensure that, at a minimum, all other system functions and information are available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m. Unavailability caused by events outside of the health plan's span of control is outside of the scope of this requirement. In the event of a declared major failure or disaster, the health plan's core eligibility/enrollment and claims processing systems shall be back online within seventy-two (72) hours of the failure's or disaster's occurrence.

2.26.9 In accordance with Executive Order 07-12, signed by the Governor of the State of Missouri on March 2, 2007, the health plan shall:

a. Support interoperable health information systems and products so long as the maintenance or exchange of health information includes provisions to protect member privacy as required by law;

b. Support the development and implementation of objective quality standards for services supplied by health care providers in that program, ultimately making provider performance on these standards available to consumers of the program's services;

c. Support making information available regarding the prices for procedures or services under the program; and

d. Make every effort to deliver high-quality and cost-effective health care that may include consumer-directed health care plans and reimbursement methods that reward providers for results.

2.27 Business Continuity and Disaster Recovery Planning:

2.27.1 The health plan shall develop, and be continually ready to implement and monitor, a business continuity and disaster recovery (BC-DR) plan. The health plan's BC-DR plan shall address: 1) the processes and strategies the health plan shall implement to ensure member access to information and services in the event of an emergency (including, but not limited to natural events, inclement weather, and declared emergencies), systems failures, and systems disruptions; and 2) the processes and strategies the health plan shall implement to resume business following an emergency (including, but not limited to natural events, inclement weather, and declared emergencies), systems failures, and systems disruptions.

2.27.2 The BC-DR plan shall, at a minimum:

a. Specify the staff responsible for oversight and administration of the plan;

b. Specify the applicable situations and emergencies and the extent to which strategies vary for each;

c. Indicate the order in which essential parties are notified of the situation and/or emergency and timeframes for notification;

d. Describe how members and providers will be notified and how they will access information and services; and

e. Describe the process for updating the plan and timeframes.

2.27.3 The health plan shall periodically, but no less than annually, perform comprehensive tests of its BC-DR plan and update as necessary. Following the effective date of the contract, the health plan shall make available to the state agency its BC-DR plan and any necessary testing results.

2.28 Records Retention:

2.28.1 The health plan shall maintain books and records relating to MO HealthNet Managed Care services and expenditures, including reports to the state agency and source information used in preparation of these reports. The books and records shall include, but are not limited to, financial statements, records relating to quality of care, medical records, and prescription files.

2.28.2 The health plan shall comply with all standards for record keeping specified by the state agency.

2.28.3 The health plan shall maintain and retain all financial and programmatic records, supporting documents, statistical records, and other records of members for five (5) years.

a. If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the five (5) year period, the health plan shall retain the records until completion of the action and resolution of all issues which arise from it or until the end of the regular five (5) year period, whichever is later.

b. Records for real property and equipment acquired with Federal funds shall be retained for three (3) years after final disposition.

c. When records are transferred to or maintained by the HHS awarding agency, the three (3) year retention requirement is not applicable to the recipient.

d. Indirect cost rate proposals, cost allocations plans, etc., as specified in Sec. 74.53(g).

2.28.4 The health plan shall retain the source records for the health plan's data reports for a minimum of five (5) years and shall have written policies and procedures for storing this information.

2.28.5 **Medical Records**: The health plan shall have and implement written policies and procedures for the maintenance of medical records so that the records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information. Complete medical records shall include but are not limited to medical charts, health status screens, prescription files, hospital records, physician specialists, consultant, and other health care professionals' findings, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided. The health plan shall make such medical records available to duly authorized representatives of the state agency and the United States Department of Health and Human Services to evaluate, through inspections or other means, the quality, appropriateness, and timeliness of services performed. The health plan shall have procedures to provide for prompt transfer of member records upon request to other in-network or out-of-network providers for the medical management of the member.

a. In accordance with Senate Bill No. 1024, enacted by the General Assembly of the State of Missouri, Section A., Chapter 334, RSMo, amended to be known as Section 334.097, physicians shall maintain an adequate and complete medical record for each member and may maintain electronic records provided the record keeping format is capable of being printed for review. An adequate and complete medical record shall include documentation of the following information:

1) Identification of the member, including name, birth date, address and telephone number;

2) The date(s) the member was seen;

3) The current status of the member, including the reason for the visit;

4) Observation of pertinent physical findings;

5) Assessment and clinical impression of diagnosis;

6) Plan for care and treatment, or additional consultations or diagnostic testing, if necessary. If treatment includes medication, the physician shall include in the medical record the medication and dosage of any medication prescribed, dispensed, or administered; and

7) Any informed consent for office procedures.

b. Medical records remaining under the care, custody, and control of the physician shall be maintained by the physician, or the physician's designee, for a minimum of seven (7) years from the date of when the last professional service was provided.

c. Any correction, addition, or change in any medical record made more than forty-eight (48) hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time, and name of the person making the correction, addition, or change shall be included, as well as the reason for the correction, addition, or change.

d. A consultative report shall be considered an adequate medical record for a radiologist, pathologist, or a consulting physician.

e. The member's medical record is the property of the provider who generates the record. Upon the written request of a member, guardian, or legally authorized representative of a member, the health plan shall furnish a copy of the medical records of the member's health history and treatment rendered. Such medical records shall be furnished within a reasonable time of the receipt of the written request. Each member is entitled to one (1) free copy of his or her medical records annually. The fee for additional copies shall not exceed the actual cost of time and materials used to compile, copy, and furnish such records.

f. The health plan shall provide the state agency with access to all members' medical records, whether electronic or paper, within thirty (30) calendar days of receipt of written request at no charge. The health plan shall provide the state agency with access to a single or small volume of medical records within five (5) calendar days of receipt of written request at no charge. The health plan shall provide the state agency with immediate access for on-site review of medical records. For on-site review of medical records, the state agency may provide the health plan with an advance notice of a partial list of medical records. The health plan shall fax or send by overnight mail to the state agency all medical records involving an emergency or urgent care issue when requested by the state agency at no charge. Access to record requirements applies to the health plan and all providers.

g. The health plan shall have written standards for documentation on the medical record for legibility, accuracy, and plan of care.

h. The health plan shall require its providers to maintain medical records in a detailed and comprehensive manner which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Medical records must be legible, signed and dated.

i. When a member changes primary care providers, upon request, his or her medical records or copies of medical records must be forwarded to the new primary care provider within ten (10) business days from receipt of request or prior to the next scheduled appointment to the new primary care provider whichever is earlier.

j. The state agency is not required to obtain written approval from a member before requesting the member's record from the provider.

k. If the state agency requests, the health plan shall gather all medical records from their providers.

2.29 Risk Adjustments, Performance Withhold Program, and Remedies for Violation, Breach, or Non-Compliance of Contract Requirements:

2.29.1 **Risk Adjusted Rates**: The state agency began risk adjusting base capitation rates effective January 1, 2013 to reflect the different health status (acuity) of the members enrolled in the health plan. The state agency shall use a statistical methodology to calculate health-based risk factors developed using a generally accepted grouper model. The specific methodology used in the applicable contract period shall be provided in Attachment 2, *Data Book*. Such risk adjustment shall be based on an aggregation of the individual risk scores of the members enrolled in the health plan and will be applied on a budget neutral basis. The state agency intends to risk adjust, where appropriate, base capitation rates on a quarterly basis. Notwithstanding any provision of the contract to the contrary, the health plan shall accept the resulting final risk adjusted rates for each risk adjustment period to occur quarterly including any retroactive adjustments as the state agency deems necessary without further contract negotiations or contract amendments.

2.29.2 **Future Rate Considerations**: In addition to the health plan payment mechanisms outlined herein, the state agency will continue to explore rate structures and payment options that enhance the ability to match payment to risk for the health plans. Specifically, the state agency and its actuary may review expanding the NICU eligible birth weight criteria and/or adjusting rates for the risk of newly enrolled Medicaid eligibles. Other rate items may also be considered upon review of emerging health plan experience. Any changes to the contract rates shall be accomplished in the form of a contract amendment.

2.29.3 **Performance Withhold Program**:

a. The Performance Withhold Program is established through the use of a withhold applied to the capitation payments made to the health plan to provide incentives for assuring health plan compliance with the requirements described herein. The total annual withhold amount will be two and a half percent (2.50%) of capitation payments each year for all three years of the contract. Withhold percentages will not be applied to supplemental payments for NICU births or deliveries. The withhold, as described herein, may be retained by the state agency based upon the specific performance requirements as outlined below. Within thirty (30) calendar days of the evaluation of the metric as outlined in the measurement schedule below, the state agency shall pay the withhold to the health plan for each performance metric met.

b. The performance metrics, populations, and individual measure withhold percentages for the first and second renewal periods of the contract are subject to change. Any such changes will be determined in consultation with a workgroup consisting of members from the state agency and each health plan. Final decisions will be made at the discretion of the state agency. Any changes to the performance metrics, populations, and individual measure withhold percentages shall be accomplished in the form of a contract amendment.

c. The Performance Withhold Program shall consist of five (5) categories of performance indicators: Encounter Data Completeness/Accuracy, Provider Panel Directory Completeness/Accuracy, HCY/EPSDT Participant Ratio, Case Management, and Medicaid Reform and Transformation Activities. The following is an outline of each of the five (5) categories of performance indicators and the associated metrics and withhold percentages for each.

1) Encounter Data Completeness/Accuracy: The state agency shall withhold half of a percent (0.50%) of monthly capitation payments made to the health plan for this performance category.

The health plan must meet each of the performance metrics below to receive the withhold amount. No partial return of the withhold amount is available for this performance category by rate cell or by region.

Encounter Data Completeness/Accuracy Specific Performance Metrics	Frequency of Metric Evaluation	Statewide vs. Regional Application	Original Contract Period Withhold Amount	Metrics Applicable during the following Contract Periods:		
				Original Contract Period	1st Renewal Period	2nd Renewal Period
1. Monthly encounter submissions must meet a ninety-eight percent (98%) acceptance rate. If the health plan is new to the MO HealthNet Managed Care Program, the health plan must transmit their first encounter data submission to the state agency by October 31, 2015 and meet a submission acceptance rate of at least eighty percent (80%) for claims incurred from July 1, 2015 to September 30, 2015. Beginning January 1, 2016, if the health plan is new to the MO HealthNet Managed Care Program, the health plan must transmit monthly encounter data submissions and meet the ninety-eight percent (98%) acceptance rate consistent with the measure for all other health plans.	Quarterly	Regional	0.50% (prorated by region) for the Original Contract Period and .17% for the 1st and 2nd Renewal Periods	Yes	Yes	Yes
2. Monthly health plan encounter volumes must be within a certain percentage of historical average volumes or regional averages if the health plan is new to the MO HealthNet Managed Care Program.	TBD	Regional	.17%	No	Yes	Yes
3. Services incurred during the contract period must be within a certain percentage of financials for the prior period after three (3) months of runout.	TBD	Regional	.17%	No	Yes	Yes

- The baseline measurements and reporting requirements will be established during the original contract period for determining the metrics in the first and second renewal periods of the contract.

2) Provider Panel Directory Completeness/Accuracy: The state agency shall withhold half of a percent (0.50%) of monthly capitation payments made to the health plan for this performance category. The health plan must meet each of the performance metrics below to receive the withhold amount. No partial return of the withhold amount is available for this performance category by rate cell or by region.

Provider Panel Directory Completeness/Accuracy Specific Performance Metrics	**Frequency of Metric Evaluation**	**Statewide vs. Regional Application**	**Original Contract Period Withhold Amount**	**Metrics Applicable during the following Contract Periods:**		
				Original Contract Period	**1st Renewal Period**	**2nd Renewal Period**
1. (A) Ninety percent (90%) of primary care providers and psychiatrists must be accepting new members, and (B) the provider directory for primary care providers and psychiatrists on a health plan's website must have a 90% accuracy rate.	Reviewed during the first six (6) months of the contract period.	Regional	0.50% months one (1) through six (6) (prorated by region)	Yes	Yes	Yes
2. Appointment wait times for primary care providers and psychiatrists must be compliant with the contract requirements seventy percent (70%) of time.	Reviewed during the second six (6) months of the contract period.	Regional	0.50% months seven (7) through twelve (12) (prorated by region)	Yes	Yes	Yes

- The types of providers measured for the provider panel performance metric are subject to change based on the health plans' performance during the original contract period.

- All metrics will be evaluated using secret shopper surveys completed on a sample set of providers in each region.

3) HCY/EPSDT Participant Ratio: The state agency shall withhold half of a percent (0.50%) of monthly capitation payments made to the health plan for this performance category. The health plan must meet the required eighty percent (80%) participant ratio for the Categories of Aid and rate cells specified for the contract period. The withhold will be returned to the health plan in full if the participant ratio is met in aggregate for the specified Categories of Aid and rate cells. No partial return of the withhold amount is available for this performance category by rate cell or by region.

HCY/EPSDT Participant Ratio Specific Performance Metrics	Frequency of Metric Evaluation	Statewide vs. Regional Application	Original Contract Period Withhold Amount	Metrics Applicable during the following Contract Periods:		
				Original Contract Period	1st Renewal Period	2nd Renewal Period
1. Eighty percent (80%) of eligible members in rate cells for children ages zero (0) to six (6) years of age are must have HCY/EPSDT well-child visits and screening. See *EPSDT Screening Codes and Methodology* located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/).	Semi-Annual	Statewide	0.50%	Yes	Yes	Yes

- The state agency may evaluate the EPSDT screening rate for different Categories of Aid and rate cells each year of the contract. The performance metric, statewide application, Categories of Aid, and rate cells chosen may be changed by the state agency's discretion.

- The screening rates will be measured using the health plans' encounter data.

4) Case Management: The state agency shall withhold a half of a percent (0.50%) of monthly capitation payments made to the health plan for this performance category. The health plan must meet each of the performance metrics below to receive the withhold amount. No partial return of the withhold amount is available for this performance category.

AMENDMENT 1 REVISED ITEM 1 ON THE FOLLOWING TABLE:

Case Management Specific Performance Metrics	Frequency of Metric Evaluation	Statewide vs. Regional Application	Original Contract Period Withhold Amount	Metrics Applicable during the following Contract Periods:		
				Original Contract Period	1st Renewal Period	2nd Renewal Period
1. The health plan must demonstrate that eighty percent (80%) of initial case management needs assessments for the pregnant women (either face-to-face or via the telephone) occur within fifteen (15) business days of notification of pregnancy.	Semi-Annual	Statewide	0.25%	Yes	Yes	Yes

Case Management Specific Performance Metrics	Frequency of Metric Evaluation	Statewide vs. Regional Application	Original Contract Period Withhold Amount	Metrics Applicable during the following Contract Periods:		
				Original Contract Period	1st Renewal Period	2nd Renewal Period
2. Timeframes for children with elevated lead levels as noted below must be met eighty percent (80%) of the time. • 45 to 69 ug/dL within 24 hours; and • 70 ug/dL or greater – immediately.	Semi-Annual	Statewide	0.25%	Yes	Yes	Yes

- The health plan shall make available to the state agency within three (3) business days upon the state agency's request supporting documentation of when the case management need was identified and when the case management contact was initiated. All documentation and additional reporting submitted by the health plan will be validated by the state agency to determine if the performance metrics have been fulfilled.

- The health conditions are subject to change at the discretion of the state agency based on the health plans' performance during the original contract period.

5) Medicaid Reform and Transformation Activities: The state agency shall withhold a half of a percent (0.50%) of monthly capitation payments made to the health plan for this performance category. The Medicaid Reform and Transformation activities are outlined herein and include Personal Responsibility, State Provider Incentive Program, Local Community Care Coordination Program, and Accountability and Transparency. The health plan must meet each of the performance metrics below to receive the withhold amount. No partial return of the withhold amount is available for this performance category by rate cell or by region.

AMENDMENT 1 REVISED ITEM 1 ON THE FOLLOWING TABLE:

Medicaid Reform and Transformation Activities Specific Performance Metrics	Frequency of Metric Evaluation	Statewide vs. Regional Application	Original Contract Period Withhold Amount	Metrics Applicable during the following Contract Periods:		
				Original Contract Period	1st Renewal Period	2nd Renewal Period
1. The health plan must receive state agency approval of the member incentive program by September 15, 2015. The health plan shall ensure ten percent (10%) of eligible members participate in the member incentive program by the end of the original contract period. The health plan must document that members accepted or declined participation in the health plan's member incentive program. The percentage of member participation in the member incentive program will increase in the first and second renewal periods based on the performance in the original contract period.	Annual	Regional	0.17% (prorated by region)	Yes	Yes	Yes
2. The health plan must receive state agency approval of the health plan's state provider incentive program by September 15, 2015. The health plan must show ten percent (10%) growth from the regional baseline measure as set forth in the state agency-approved state provider incentive program plan submitted by the health plan. For the original contract period, the state agency will evaluate primary care providers, physician specialists, and behavioral health specialists. The health plan must grow its state provider incentive program by the same percentage in the first and second renewal periods.	Annual	Regional	0.17% (prorated by region)	Yes	Yes	Yes

Medicaid Reform and Transformation Activities Specific Performance Metrics	Frequency of Metric Evaluation	Statewide vs. Regional Application	Original Contract Period Withhold Amount	Metrics Applicable during the following Contract Periods:		
				Original Contract Period	1st Renewal Period	2nd Renewal Period
3. The health plan must submit the LCCCP application and program model to the state agency by December 31, 2015. The health plan must receive state agency approval of the LCCCP plan by April 1, 2016. For the first renewal period, the health plan must provide proof that ten percent (10%) of members are either enrolled in the LCCCP or have "declined to participate" in the LCCCP. For the second renewal period, the health plan must provide proof that twenty-five percent (25%) of members are either enrolled in the LCCCP or have "declined to participate" in the LCCCP.	Annual	Regional	0.17% (prorated by region)	Yes	Yes	Yes

- For purposes of evaluating the second metric in this performance category (the state provider incentive program metric), the state agency will only assess certain types of providers during each year of the contract. The health plan is not precluded from offering up incentives to all provider types, but for the purpose of this withhold, provider types not specified will not be evaluated during that contract period.

- For the third metric in this performance category (the LCCCP incentive metric), the health plan is only required to submit one LCCCP plan in the original contract period. The LCCCP should address regional distinctions where necessary; however, the health plan is not required to submit a separate LCCCP plan for each region.

- The reporting for this performance category will be further defined as part of the approval process for each LCCCP plan. Reporting templates will be prepared by the state agency as necessary.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

d. The tables above specify whether metrics will be evaluated on a statewide or regional basis. The state agency will evaluate statewide metrics by evaluating aggregate data across all regions on an overall basis against the metric requirement. The state agency will evaluate regional metrics by evaluating data for each region individually against the metric requirement. The withhold percentages for regional metrics will be prorated by region. Return of the withhold for each regional metric will be available if the health plan meets the requirement for a specific region.

e. No interest shall be due to the health plan on any sums withheld or retained under this section. The provisions of this section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under the contract.

2.29.4 **Liquidated Damages**: The health plan shall agree and understand that the provision of the managed care medical service delivery system in accordance with the requirements stated herein is considered critical to the efficient operations of the State of Missouri. However, since the amount of actual damages would be difficult to establish in the event the health plan fails to comply with the requirements, the health plan shall agree and understand that the amount identified below as liquidated damages shall be reasonable and fair under the circumstances.

a. Reports and Deliverables: For each working day that a report or deliverable that is required herein is late, incorrect, or deficient, the health plan shall be liable to the state agency for liquidated damages in the amount indicated in the chart below. The contractor shall ensure that the mode of delivery of the reports and deliverables includes a return receipt. The health plan shall maintain this receipt in their files for audit purposes.

MONTHLY REPORTS	
Report Requirement	**Liquidated Damage Assessment**
Federally Qualified Health Center and Rural Health Clinic M-1 Instructions and Forms	$100.00 per day per report or deliverable.
Special Health Needs Report	$100.00 per day per report or deliverable.
Lead Poisoning Prevention Report	$100.00 per day per report or deliverable.
Monthly confirmation letter that the health plan is compliant with contractual requirement to review provider exclusion.	$100.00 per day per report or deliverable.

QUARTERLY REPORTS	
Report Requirement	**Liquidated Damage Assessment**
Third Party Savings Reports	$100.00 per day per report or deliverable.
Complaint, Grievance, and Appeal Report	$100.00 per day per report or deliverable.
Fraud, Waste, and Abuse Activities Report	$100.00 per day per report or deliverable.
Timeliness of Claims Adjudication Report	$100.00 per day per report or deliverable.
Case Management Log	$100.00 per day per report or deliverable.
Behavioral Health Case Management Survey Instructions	$100.00 per day per report or deliverable.
Disease Management Report	$100.00 per day per report or deliverable.
Call Center Report	$100.00 per day per report or deliverable.

SEMI-ANNUAL REPORTS	
Report Requirement	**Liquidated Damage Assessment**
Unaudited Health Plan Financial Reporting Form Must be provided to the state agency's contracted actuary.	$100.00 per day per report or deliverable.
Health Plan Encounter Data Questionnaire Must be provided to the state agency.	$100.00 per day per report or deliverable.

ANNUAL REPORTS	
Report Requirement	**Liquidated Damage Assessment**
Report of contracted entities. Federally Qualified Health Centers, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Family Planning and STD Providers	$100.00 per day per report or deliverable.
Disclosure of Physician Incentive Plans.	$100.00 per day per report or deliverable.
Audited Health Plan Financial Reporting Form Must be provided to the state agency's contracted actuary.	$100.00 per day per report or deliverable.

ANNUAL REPORTS	
Report Requirement	**Liquidated Damage Assessment**
Health Plan Encounter Data Questionnaire	$100.00 per day per report or deliverable.
Annual Verification of Review of Education and Marketing Materials	$100.00 per day per report or deliverable.
HEDIS Measures	$100.00 per day per report or deliverable.
Quality Assessment and Improvement Evaluation Report	$100.00 per day per report or deliverable.
Subcontractor Oversight Annual Evaluation Report	$100.00 per day per report or deliverable.
Member satisfaction data/report (CAHPS) to DHSS per 19 CSR 10-5.010.	$100.00 per day per report or deliverable.
Trends in Missouri MO HealthNet Quality Indicators to the Department of Health and Senior Services	$100.00 per day per report or deliverable
HEDIS Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births	$100.00 per day per report or deliverable

MISCELLANEOUS DELIVERABLES The following deliverables are required upon request by the state agency, within the timeframe specified by the state agency at the time of request, or as specified herein.	
Report Requirement	**Liquidated Damage Assessment**
Federally Qualified Health Centers and Rural Health Clinic M-2 Instructions and Forms	$100.00 per day per report or deliverable.
Modifications, additions, or deletions to policies and procedures as required in Policies and Procedures Requiring Prior Approval.	$100.00 per day per report or deliverable.
Local Community Care Coordination Activities and Expenditures Report	$100.00 per day per report or deliverable.
Periodic Reports of Quality and Utilization	$100.00 per day per report or deliverable.
Inform the state agency in writing of staffing changes for specified key positions.	$100.00 per day per report or deliverable.
Changes to the composition of the health plan provider network or health care service subcontractor's provider network that materially affect availability of covered services.	$100.00 per day per report or deliverable.
Report to the state agency when the health plan providers have reached 85% capacity.	$100.00 per day per report or deliverable
Changes to physician incentive plans.	$100.00 per day per report or deliverable.
Use of guidelines for maternity benefits other than those specified in the contract.	$100.00 per day per report or deliverable.
Offering of additional health benefits or discontinuing such benefits.	$100.00 per day per report or deliverable.
Notify state agency of any discrepancies of weekly reconciliation of enrollment file.	$100.00 per day per report or deliverable
Member handbook	$100.00 per day per report or deliverable.
Request to disenroll member	$100.00 per day per report
Member's acute inpatient hospitalization on effective date of coverage	$100.00 per day per report or deliverable.
Marketing plan, all marketing materials, and member education materials	$100.00 per day per report or deliverable.
All materials used by in-network providers to advise members of the health plans with which they have contracts.	$100.00 per day per report or deliverable.

MISCELLANEOUS DELIVERABLES The following deliverables are required upon request by the state agency, within the timeframe specified by the state agency at the time of request, or as specified herein.	
Report Requirement	**Liquidated Damage Assessment**
Notification of community activity at provider sites.	$100.00 per day per report or deliverable.
Gifts offered during any community activity.	$100.00 per day per report or deliverable.
Use of MHD or DSS name, logo, or other identifying marks on any materials produced or issued.	$100.00 per day per report or deliverable.
Publicity prepared by or for the health plan.	$100.00 per day per report or deliverable.
Member notification of changes in health plan operations.	$100.00 per day per report or deliverable.
Written member notifications.	$100.00 per day per report or deliverable.
Member grievance system notices.	$100.00 per day per report or deliverable.
Member grievance system policies and procedures.	$100.00 per day per report or deliverable.
Member flyer explaining grievance system.	$100.00 per day per report or deliverable.
Provider Notifications.	$100.00 per day per report or deliverable.
Provider complaints and appeals policies and procedures.	$100.00 per day per report or deliverable.
Results of health plan internal monitoring, evaluation, and action plan implementation.	$100.00 per day per report or deliverable.
Member Incentives.	$100.00 per day per report or deliverable.
Furnish annual updated information required in O*wnership or Controlling Interest Disclosure* and *Transaction Disclosure Reports*.	$100.00 per day per report or deliverable.
Provide information concerning uniform utilization, quality assessment and improvement, enrollee satisfaction, complaint, grievance, and appeal, and fraud and abuse detection data on a regular basis. Periodically make available clinical outcome data.	$100.00 per day per report or deliverable.
Publishing or making formal public presentations of statistical or analytical material based on the health plan's enrollment.	$100.00 per day per report or deliverable.
Submit behavioral health data in accordance with *Healthcare Quality Data Template and Instructions.*	$100.00 per day per report or deliverable.
Provide access to members' medical records within thirty (30) calendar days of request. Provide access to a single or small volume of medical records within five (5) calendar days of request. Fax or overnight mail medical records involving emergency or urgent care issues upon request.	$100.00 per day per report or deliverable.
Acceptable action plan for correcting administrative services failure.	$100.00 per day per report or deliverable.
Changes to approved fraud and abuse plan.	$500.00 per calendar day per report or deliverable.
Furnish updated ownership and financial disclosure information within 35 days of a written request.	$500.00 per calendar day per report or deliverable.

MISCELLANEOUS DELIVERABLES The following deliverables are required upon request by the state agency, within the timeframe specified by the state agency at the time of request, or as specified herein.	
Report Requirement	**Liquidated Damage Assessment**
Furnish provider/subcontractor disclosure information annually at contract renewal or within 35 days of a written request.	$500.00 per calendar day per report or deliverable.
Lock-in member notices.	$100.00 per day per report or deliverable.
Lock-in policies and procedures.	$100.00 per day per report or deliverable.
Identification and notification of the name, title, address, and telephone number of one duly authorized representative.	$100.00 per day per report or deliverable.
Disclose if any funds other than those paid to the MO HealthNet Managed Care health plan by the state agency have been used or will be used to influence persons or entities indicated.	$100.00 per day per report or deliverable.
Notice of any use or disclosure of the Protected Health Information not permitted or required.	$100.00 per day per report or deliverable.
Notice health plan does not intend to renew the contract for the second renewal option.	$100.00 per day per report or deliverable.
Evidence of adequate liability insurance.	$100.00 per day per report or deliverable.
Notification if insurance coverage is canceled.	$100.00 per day per report or deliverable.
Establishing any new subcontracting arrangements and before changing any subcontractors.	$100.00 per day per report or deliverable.
Transfer of any interest in the contract whether by assignment or otherwise requires prior written consent of the Division of Purchasing and Materials Management.	$100.00 per day per report or deliverable.
Release of reports, documentation, or material prepared as required by the contract.	$100.00 per day per report or deliverable.

b. Program Requirements: Liquidated damages for failure to perform specific program responsibilities as described herein are shown in the chart below.

PROGRAM RESPONSIBILITY	LIQUIDATED DAMAGE ASSESSMENT FOR BREACH
Failure to meet claims processing timeframes and other requirements herein	$10,000.00 per month, for each month that the state agency determines that the health plan is not in compliance with the requirements
Failure to submit quality assessment and improvement reports as required herein	$250.00 per day for every calendar day reports are late
Failure to maintain NCQA accreditation	$500.00 per day for every calendar day in which the health plan provides services after the expiration of NCQA accreditation
Failure to obtain approval of member materials as required herein	$500.00 per day for each calendar day that the state agency determines the health plan has provided member material that has not been approved by the state agency
Failure to comply with timeframes for providing member handbooks, identification cards, and provider directories	$500.00 for each occurrence

PROGRAM RESPONSIBILITY	LIQUIDATED DAMAGE ASSESSMENT FOR BREACH
Failure to comply with fraud, waste, and abuse provisions herein (including health plan activities to monitor and combat both provider and member fraud, waste, and abuse)	$500.00 per calendar day for each day that the health plan does not comply with fraud, waste, and abuse provisions
Failure to require and ensure compliance with ownership and disclosure requirements herein	$5000.00 per provider attestation, subcontracted benefit management organization attestation, or health plan attestation that is not provided timely or does not contain complete and satisfactory information as required in 42 CFR Part 455
Failure to maintain a grievance and appeal system as required herein	$500.00 per calendar day
Failure to maintain required insurance as required herein	$500.00 per calendar day
Imposition of utilization controls or other quantitative coverage limits that arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition as prohibited herein	$500.00 per occurrence
Failure to process credentialing applications or to maintain provider agreements as required herein	$5000.00 per credentialing application or provider agreement found to be handled in breach of the contract
Failure to comply with staffing requirements described herein	$250.00 per calendar day for each day that staffing requirements are not met
Failure to comply with requirements concerning work authorization of health plan employees (including attestation)	$500.00 per calendar day for each day that work authorization requirements are not met

c. In addition to the liquidated damages described above, the state agency reserves the right to assess a general liquidated damage of five hundred dollars ($500.00) per occurrence with any notice of deficiency.

d. The health plan shall understand that the liquidated damages described herein shall not be construed as a penalty.

e. The health plan shall agree and understand that all assessments of liquidated damages shall be within the discretion of the State of Missouri and shall be in addition to, not in lieu of, the rights of the State of Missouri to pursue other appropriate remedies.

f. The health plan shall also agree and understand that such liquidated damages shall either be deducted from the health plan's capitated payments pursuant to the contract or paid by the health plan as a direct payment to the state agency at the sole discretion of the state agency

2.29.5 Notwithstanding the state agency's imposition on the health plan of any remedy or sanction, including liquidated damages, the health plan shall continue to perform all services under the contract except as specifically provided herein.

2.29.6 **Remedies for Failure to Provide Covered Services or to Perform Administrative Services**:

a. In the event the state agency determines the health plan failed substantially to provide one or more medically necessary covered services as required herein, the state agency shall direct the health plan to provide such service. If the health plan continues to refuse to provide the covered service(s), the state agency 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 (at the state agency's discretion)

either the actual amount of the cost of such service or $500.00 per occurrence. In such event, the charges to the health plan shall be obtained by the state agency in the form of deductions of that amount from the next monthly capitation payment made to the health plan. With such deductions, the state agency shall provide a list of the members with respect to whom payments were deducted, the nature of the service(s) that the health plan failed to provide, and payments the state agency made or will make to provide the medically necessary covered services. Use of the remedy under this section shall not foreclose the state agency from imposing any other applicable remedy listed herein. The failure to provide a covered service timely (i.e., in accordance with the timeframes specified herein, or when not specified herein, with reasonable promptness) shall be considered a violation resulting in either the actual amount of the cost of the service or $500.00 per occurrence.

b. In the event of any failure by the health plan to provide any services under the contract (including both covered services and administrative services), the state agency may, in addition to any other applicable remedies listed herein, require the health plan to submit and follow a corrective action plan, in order to ensure that the health plan corrects the error or resumes providing the service. If the state agency chooses to impose this remedy, the state agency shall issue to the health plan a notice of deficiency identifying the health plan's failure, and setting forth required timeframes in which the health plan shall resolve each violation. Within five (5) business days of receipt of the notice of deficiency, the health plan shall submit to the state agency a corrective action plan. For purposes of this section, "administrative services" are defined as any contract requirements other than the actual provision of covered services.

1) If the corrective action plan submitted by the health plan is acceptable to the state agency, no remedial action under this subsection shall be taken by the state agency, provided that the health plan implements the corrective action as approved by the state agency.

2) If the health plan fails to submit a corrective action plan within the five (5) business days of receipt of the notice of deficiency, fails to submit a revised correction plan in the timeframe specified by the state agency, or fails to implement the accepted corrective action plan within the timeframe required by the state agency, the state agency shall withhold payment from the next capitation payment due the health plan as stated below:

- The amount withheld shall be no less than $500.00 per calendar day, and may be higher, in the State's discretion, save that for any month the total amount withheld shall not exceed three percent (3%) of the total amount of the monthly capitation payment due the health plan.

  - For violations lasting for more than one month, the state agency shall continue to withhold up to three percent (3%) from subsequent monthly capitation payments until successful correction of the services failure by the health plan.

  - After successful correction of the services failure, the state agency may, in its discretion, pay the health plan the total amount of all payments withheld under this subsection.

  - The state agency may monitor the effectiveness of the health plan's implementation of a corrective action plan by, among other measures, requiring reporting by the health plan and making site visits to the health plan.

2.29.7 **Remedies for Failure to Comply with Marketing Requirements**: In the event the state agency determines that the health plan has failed to comply with any of the marketing requirements of the contract, one or more of the remedial actions listed below (in addition to any other applicable remedies described herein) shall apply. The state agency shall notify the health plan in writing of the determination of the non-compliance, of the action(s) that must be taken, and of any other conditions related thereto

such as the length of time the remedial actions shall continue and of the corrective actions that the health plan shall perform.

a. The state agency shall require the health plan to recall the previously authorized marketing materials.

b. The state agency shall suspend enrollment of new members to the health plan.

c. The state agency shall 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.

d. The state agency shall 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 and inform the member of his or her right to transfer to another health plan.

e. The state agency shall prohibit future marketing activities by the health plan for an amount of time specified by the state agency.

2.29.8 **Basis for Imposing Intermediate Sanctions**: In addition to the above, the state agency may impose intermediate sanctions when a health plan acts or fails to act as specified below. Before imposing intermediate sanctions, the state agency shall give the health plan timely written notice that identifies the violation and explains the basis and nature of the sanction. A health plan is subject to intermediate sanctions if it:

a. 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.

b. Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the MO HealthNet program.

c. Acts to discriminate among members on the basis of their health status or need for health care services.

d. Misrepresents or falsifies information that it furnishes to CMS or to the state agency.

e. Misrepresents or falsifies information that it furnishes to a member, potential member, or a health care provider.

f. Fails to comply with the requirements for Physician Incentive Plans as set forth (for Medicare) in 42 CFR 422.208 and 422.210.

g. Distributes directly or indirectly through any agent or independent subcontractor, marketing materials that have not been approved by the state agency or that contain false or materially misleading information.

h. Violates any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

2.29.9 **Types of Intermediate Sanctions**: The types of intermediate sanctions that the state agency may impose upon the health plan include:

a. Civil monetary penalties in the following specified amounts:

1) A maximum of $25,000.00 for each determination of failure to provide services; misrepresentation or falsification of statements to members, potential members, or health care providers; failure to comply with PIP requirements; or marketing violations.

2) A maximum of $100,000.00 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 the state agency.

3) A maximum of $15,000.00 for each member the state agency determines was discriminated against based on the member's health status or need for services (subject to the $100,000 limit above).

4) The greater of $25,000.00 or double the amount of the excess charges for charging premiums or charges in excess of the amounts permitted under the MO HealthNet program. The state agency shall return the amount of overcharge to the affected member(s).

b. Appointment of temporary management for a health plan as provided herein and in 42 CFR 438.706.

c. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll.

d. Suspension of all new enrollments, including default enrollment, after the effective date of the sanction.

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

f. Additional sanctions as set forth herein or in State law or State regulation.

2.29.10 **Special Rules for Temporary Management**: The state agency shall impose the sanction of temporary management on the health plan in the following circumstances.

a. Temporary management may be imposed by the state agency only if the state agency finds that:

1) There is continued egregious behavior by the health plan, including, but not limited to behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Act;

2) There is substantial risk to members' health; or

3) The sanction is necessary to ensure the health of the health plan's members while improvements are made to remedy violations under 42 CFR 438.700 or until there is an orderly termination or reorganization of the health plan.

b. The state agency shall impose temporary management if the state agency finds that the health plan has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the Act. The state agency shall also grant members the right to terminate enrollment without cause and shall notify the affected members of their right to terminate enrollment.

c. The state agency's election to appoint temporary management shall not act as an implied waiver of the State's right to terminate the contract, suspend enrollment, or to pursue any other remedy available to the State under the contract.

2.29.11 **Legal Actions and Attorney Fees**: In addition to the above described rate adjustments and remedies, if the state agency determines that the health plan is not taking proper action to correct the identified failures, the state agency shall have the right to implement any other legal processes deemed necessary including, but not limited to, cancellation of the contract, recovery of damages, and suspension of new enrollments in the health plan. In the event the state agency 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 damages, 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.

2.29.12 **Federal Sanctions**: Section 1903(m)(5) of the 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 ("new members"). In addition to any sanctions and actions specified above, the state agency shall deny payments under the contract with respect to new members when, and for so long as, payment for the new members is denied by the Secretary of Health and Human Services under the authority of Section 1903(m)(5) of the Act or 42 CFR 438.730. Payments may be denied for reasons, including but not limited to, the following:

a. Substantial failure to provide a member with medically necessary items or services that the health plan is required to provide, under law or under the contract, when the failure has adversely affected (or has a substantial likelihood of adversely affecting) the member;

b. Discrimination among individuals in violation of Section 1903(m)(2)(A)(v) of the Act, including expulsion or refusal to re-enroll an individual or engage in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as otherwise permitted by statute) by eligible individuals with the health plan whose medical condition or history indicates a need for substantial future medical services;

c. Misrepresentation or falsification of certain information furnished to the Secretary of Health and Human Services, the state agency, an individual, or to any other managed care entity; or

d. Failure to comply with the requirements for PIPs as specified herein and as set forth (for Medicare) in Section 1876(i)(8) of the Act.

2.29.13 **Termination of a Health Plan Contract**:

a. Nothing in this section shall limit the State's right to terminate the contract or to pursue any other legal or equitable remedies. Pursuant to 42 CFR 438.708, the State may terminate the contract as a sanction and enroll the health plan's members in other health plans or provide their benefits through other options included in the State plan if the state agency, 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 and 1903(m) of the Act.

b. After the State notifies the health plan that it intends to terminate the contract, the state agency may do the following:

   1) Give the health plan's members written notice of the State's intent to terminate the contract; or

   2) Allow members to disenroll immediately without cause.

c. Before terminating a health plan's contract under 42 CFR 438.708, the state agency shall provide the health plan a pre-termination hearing. The state agency shall:

1) Give the health plan written notice of its intent to terminate, the reason for termination, and the time and place of the pre-termination hearing;

2) Give the health plan (after the pre-termination hearing) written notice of the decision affirming or reversing the proposed termination of the contract, and for an affirming decision, the effective date of termination; and

3) For an affirming decision, give members of the health plan notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving Medicaid services following the effective date of termination.

2.29.14 If the state agency receives written notice from the United States Department of Health and Human Services that the health plan does not meet the definition of an HMO as set forth in the Medicaid State Plan and 42 CFR 434 or receives written notice from the Department of Insurance, Financial Institutions & Professional Registration that the health plan does not have a certificate of authority to establish or operate an HMO, the Division of Purchasing and Materials Management may cancel the contract with the health plan pursuant to contract cancellation provisions contained herein.

2.30 Access to Premises: During normal business hours (defined as 8:00 a.m. through 5:00 p.m., Monday through Friday, except State designated holidays), the health plan shall allow duly authorized agents or representatives of the Federal or State government access to the health plan's premises or the health plan's subcontractor's premises to inspect, audit, monitor, or otherwise evaluate the performance of the health plan or its subcontractors.

2.31 Advance Directives:

2.31.1 The health plan shall have and implement written policies and procedures related to advance directives. At the time of enrollment, the health plan shall provide written information to all adult members regarding the member's rights under the Missouri law to make decisions concerning medical care.

2.31.2 The health plan shall provide education to the health plan's personnel and members on issues concerning advance directives.

2.31.3 The above provisions shall not be construed to prohibit the application of any Missouri law which allows for an objection on the basis of conscience for any provider or agent of such provider.

2.32 Fraud, Waste, and Abuse

2.32.1 **Definitions**:

a. The following definitions are taken from "Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care", A Product of the National Medicaid Fraud and Abuse Initiative, Health Care Financing Administration National Initiative, October 2000:

1) Medicaid Managed Care Fraud: Any type of intentional deception or misrepresentation made by an entity or person in a capitated Managed Care Organization (MCO), Primary Care Case Management (PCCM) program, or other managed care setting with the knowledge that the deception could result in some unauthorized benefit to the entity, himself, or some other person.

2) Medicaid Managed Care Abuse: Practices in a capitated MCO, PCCM program, or other managed care setting that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are

not medically necessary or that fail to meet professionally recognized standards or contractual obligations for health care. The abuse can be committed by an MCO, contractor, subcontractor, provider, State employee, Medicaid beneficiary, or Medicaid managed care enrollee, among others. It also includes beneficiary practices in a capitated MCO, PCCM program, or other managed care setting that result in unnecessary cost to the Medicaid program or MCO, contractor, subcontractor, or provider. It should be noted that Medicaid funds paid to an MCO, then passing to subcontractors, are still Medicaid funds from a fraud, waste, and abuse perspective.

2.32.2 **Fraud, Waste, and Abuse and Program Integrity Policies**:

a. The health plan shall implement internal controls, policies, and procedures designed to prevent, detect, review, report to the state agency, and assist in the prosecution of fraud, waste, and abuse activities by providers, subcontractors, and members. The policies and procedures shall articulate the health plan's commitment to comply with all applicable Federal and State standards. In order to implement the above, the health plan shall submit a written fraud, waste, and abuse plan to the state agency for approval prior to implementation. Any changes to the approved fraud, waste, and abuse plan must have state agency approval prior to implementation.

b. The health plan's fraud, waste, and abuse plan must include, but is not limited to, the following components:

1) Provision stating that if a network provider submits fraudulent billings to the MO HealthNet Managed Care health plan, any recoveries associated with the fraudulent billing will be recovered by the State and not the health plan if the health plan previously reported those costs in a cost report used to establish rates. If, however, the fraudulent billing and recovery is done in a period where cost reports have not been submitted by the MO HealthNet Managed Care health plan for that service period, then the recovery shall go to the health plan and the health plan shall not report any of the medical costs associated with the fraudulent billings in the cost report;

2) The designation of a compliance officer and a compliance committee that are responsible for the health plan's fraud, waste, and abuse program and activities. The compliance officer is supervised by and reports to the Chief Executive Officer (CEO), Health Plan Administrator, or the governing body;

3) A procedure to ensure effective lines of communication between the compliance officer and the health plan's personnel;

4) Provision for a data system, resources, and staff to perform the fraud, abuse, and other compliance responsibilities;

5) Procedures for internal prevention, detection, reporting, review, and corrective action;

6) Procedures for prompt response to detected offenses;

7) Procedures for reporting to the state agency, including the requirement of a quarterly fraud, waste, and abuse report and the use of State approved forms;

8) Written standards for organizational conduct;

9) A compliance committee that periodically meets and documents review of compliance issues. These issues include fraud, abuse, and regulatory and contractual compliance.

10) Effective training and education for the compliance officer and the health plan's personnel, management, board members, and subcontractors;

11) Inclusion of information about fraud, waste, and abuse identification and reporting in provider and member materials; and

12) Enforcement of standards through well-publicized disciplinary guidelines.

c. The health plan's activities to combat fraud, waste, and abuse shall include, but not be limited to the following:

1) Conducting regular reviews and audits of operations, and provider and member conduct to guard against fraud, waste, and abuse;

2) Assessing and strengthening internal controls to ensure claims are submitted and payments are made properly, and that only MO HealthNet Managed Care members are served under the contract;

3) Requesting documentation from adult MO HealthNet members, such as MO HealthNet identification card (or other documentation provided by the state agency demonstrating MO HealthNet eligibility), as well as the health plan membership card prior to accessing non-emergency services;

4) Educating employees, network providers, and beneficiaries about fraud, waste, and abuse and how to report it;

5) Use of effective organizational resources to respond to complaints of fraud, waste, and abuse;

6) Establishing procedures to process fraud, waste, and abuse complaints;

7) Establishing procedures for reporting information to the state agency; and

8) Developing procedures to monitor utilization/service patterns of providers, subcontractors, and beneficiaries.

d. The health plan shall initiate an immediate investigation to gather facts regarding any suspected fraud or abuse by providers or members. The health plan shall notify the state agency of all suspected fraud or abuse, as provided herein, in keeping with Federal requirements at 42 CFR 455.13. In addition, the health plan shall provide reports of its investigative, corrective, and legal activities to the state agency in accordance with contractual and regulatory requirements.

e. The health plan and its subcontractors shall cooperate fully in any State or Federal reviews or investigations, including the preliminary and full investigations referenced in 42 CFR Part 455, Subpart A (Medicaid Agency Fraud Detection and Investigation Program), and in any subsequent legal action.

f. The health plan shall implement corrective actions in instances of fraud, waste, and abuse detected by the state agency, or other authorized agencies or entities. The health plan shall suspend payment to any provider, pending any State or Federal review or investigation of suspected fraud or abuse, if so instructed by the state agency.

g. Failure on the part of the health plan to adhere to all Federal and State fraud, waste, and abuse requirements and standards may subject the health plan to sanctions as described herein.

h. Once the health plan has referred a suspected case of fraud, waste, or abuse to the state agency, the health plan shall take no action to recoup or otherwise offset any suspected overpayments until the state agency provides written notice to the health plan that the fraud, waste, or abuse case has been closed or otherwise dispositioned. At that time, and after conducting a cost benefit analysis to determine if such action is warranted, the health plan should attempt to recover any overpayments identified. The Health and Human Services Department Office of the Inspector General (OIG) shall be advised of the final disposition of the research and advised of actions, if any, taken by the health plan.

2.32.3 **Member Lock-In**:

a. The health plan shall conduct a member lock-in program in accordance with 13 CSR 70-4.070, as amended. At a minimum, the health plan shall evaluate utilization patterns of its members to identify members for lock-in, initiate and manage lock-in procedures and activities, and notify members of their rights to grieve the lock-in.

b. The health plan shall submit its lock-in policies and procedures to the state agency for review and approval prior to implementing the program.

c. The health plan is not responsible for the implementation of a lock-in program for pharmacy services; this is the responsibility of the state agency.

2.32.4 **Fraud, Waste, and Abuse Reporting**:

a. Quarterly Reporting: On a quarterly basis, the health plan shall report to the state agency all instances of suspected provider fraud, abuse, or waste, or member abuse of services covered under the contract, using a format, data elements, and frequency prescribed by the state agency in the *Fraud, Waste or Abuse Activities Report* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/). The health plan shall follow the requirements outlined in the MO HealthNet Managed Care Policy Statements found in *MO HealthNet Managed Care Policy Statements* located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/).

2.32.5 **Other Fraud, Waste, and Abuse Reporting**:

a. The health plan shall report to the state agency, within one (1) business day of receiving such information, any information concerning member fraud, waste, or abuse. This includes information that the health plan receives concerning an adult member or other person who is suspected of fraudulently transferring his or her MO HealthNet identification card or health plan membership card to another person, or of fraudulently using another person's card in order to access health services.

b. Within one (1) business day of initiating an investigation, the health plan shall report to the state agency on the suspected case(s) of provider fraud, waste, and abuse. In addition, the health plan shall provide reports to the state agency on the outcomes of its investigations. This requirement does not supplant the requirement, contained herein, that the health plan submit to the state agency a quarterly fraud, waste, and abuse report.

c. The state agency shall refer to the MFCU the information reported by the health plan under this subsection, if the reports of suspected fraud or abuse are substantiated by the state agency's preliminary investigation (see 42 CFR Part 455, Subpart A).

2.32.6 **Identification of Debarred Individuals or Excluded Providers in Health Plans**:

a. The health plan shall exclude providers from the health plan network that have been identified as having Office of Inspector General (OIG) sanctions, having failed to renew license or certification registration, having a revoked professional license or certification, or have been terminated by the state agency.

b. The health plan shall not contract with, or otherwise pay for any items or services furnished, directed, or prescribed by a provider that has been excluded from participation in federal health care programs by the OIG of the U.S. Department of Health and Human Services under either 1128 or section 1128A of the Social Security Act, except as permitted under 42 CFR 1001.1801 and 1001.1901.

c. The health plan can access debarred and OIG (https://oig.hhs.gov) sanction information on the Internet. The health plan shall also access information from the Professional Registration Boards Internet site (http://pr.mo.gov) to identify State initiated terminations.

d. The health plan shall promptly notify the state agency, using the format provided in the *Provider and Subcontractor Disclosure* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/), when it learns that a provider in its network has been debarred. The state agency shall report such information to the Secretary of Health and Human Services, as required by 42 CFR 438.610(c).

e. The health plan shall on a monthly basis submit a letter to the state agency to confirm that the health plan is compliant with the contractual requirement to review provider exclusions.

f. The state agency or its authorized agent shall conduct a periodic review to determine if appropriate exclusions and corrective action have occurred.

BAFO 001 REVISED THE FOLLOWING PARAGRAPH:

2.32.7 **Disclosure of Ownership and Control Information, Criminal Convictions, and Significant Business Transactions**: Within thirty-five (35) days of a written request from the state agency, the health plan shall disclose to the state agency full and complete information regarding ownership, financial transactions, and persons convicted of criminal activity related to Medicare, Medicaid, or the Federal Title XX programs in accordance with Federal and State requirements, including Public Chapter 379 of the Acts of 1999 and 42 CFR 455.104-106 and 42 CFR 1001.1001-1051. This disclosure shall be made in accordance with the requirements herein and in the format and frequency specified by the state agency in the "*Ownership or Controlling Interest Disclosure", "Transaction Disclosures",* and *"Provider and Subcontractor Disclosure"* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates.

2.32.8 In accordance with 42 CFR 455.106(b), the state agency shall notify the HHS Office of the Inspector General (OIG) within twenty (20) business days of any disclosures made by the health plan under 42 CFR 455.106 (relating to criminal convictions of the provider, or of a person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider).

2.32.9 The State shall terminate the contract with the health plan if the State determines at any time that the health plan has been excluded by OIG under 42 CFR 1001.1001 (relating to OIG exclusion of entities owned or controlled by a sanctioned person) or 1001.1051 (relating to OIG exclusion of individuals with ownership or control interest in sanctioned entities); or that the health plan has, directly or indirectly, a substantial contractual relationship with an individual or entity that has been excluded by OIG under those regulations.

2.32.10 At a minimum, as part of the initial screen, the state agency shall screen the health plan, and their personnel, to determine whether any of the health plan or the health plan's personnel have been excluded from participation in Medicare, Medicaid, CHIP, or any other Federal health care program (as defined in Section 1128B(f) of the Act); has failed to renew license or certification registration; has revoked professional license or certification; or has been terminated by the state agency. In conducting this screening, the state agency will consult the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS) on at least a monthly basis; and, consistent with State and Federal timeframes, the National Plan and Provider Enumeration System (NPPES), the Missouri Professional Registration Boards website, as well as any such other Federally required databases or databases as the state agency deems appropriate. The LEIE is located at https://oig.hhs.gov/exclusions/exclusions_list.asp and the EPLS is located at https://www.sam.gov/portal/public/SAM/.

2.33 Other Administrative Requirements:

2.33.1 **Member Explanation of Benefits (EOB)**:

a. The health plan shall provide an EOB to members upon request. In addition, on a quarterly basis, the health plan shall issue EOBs to members receiving services based on a statistically valid sample, with a level of confidence of ninety-five percent (95%). The health plan shall ensure that the EOBs constitute a representative sample of service types and provider types.

b. The EOB shall consist of:

1) A list of services provided and billed to the health plan;

2) The name of the provider furnishing the service;

3) The date on which the service was furnished; and

4) Paid and unpaid claims. For any unpaid claims, the health plan shall provide the reason the claim was not paid.

c. The health plan shall develop and implement a process to track and monitor all EOB requests. The process shall include, at a minimum:

1) The date of each EOB request;

2) The name of the member requesting the EOB;

3) The date the EOB is provided to the member;

4) Any complaint received from members as a result of an EOB, including date of complaint and nature of complaint; and

5) Resolution of the complaint, including date of resolution.

d. The health plan shall make copies of EOBs and monitoring results available to the state agency upon request.

2.33.2 **MO HealthNet Consumer Advocacy Project Meetings**: The health plan shall meet with the MO HealthNet Consumer Advocacy Project three (3) times per year to discuss trends of program occurrences, both positive and negative, and to discuss the services provided by the health plan during the period. At least one of the meetings will be face-to-face with the MO HealthNet Consumer Advocacy Project.

2.34 Other State and Federal Legal Compliance Requirements:

2.34.1 Unless otherwise specified herein, the health plan shall furnish all materials, labor, facilities, equipment, and supplies necessary to perform the service required herein.

2.34.2 Within five (5) business days after issuance of the Notice of Award by the Division of Purchasing and Materials Management, the health plan shall submit a written identification and notification to the state agency of the name, title, address, and telephone number of one (1) individual within its organization as a duly authorized representative to whom all correspondence, official notices, and requests related to the health plan's performance under the contract shall be addressed. The health plan shall have the right to change or substitute the name of the individual described above as deemed necessary provided that the state agency is notified immediately.

2.34.3 The health plan shall understand and agree that the contract, in part, shall implement the MO HealthNet Managed Care Program. Therefore, the health plan shall conform to such requirements or regulations as the United States Department of Health and Human Services issues.

2.34.4 The health plan shall understand and agree that the MO HealthNet Managed Care Program is subject to modification by the Missouri General Assembly, the State of Missouri, and the United States Department of Health and Human Services. Any changes to the program shall be made via notification to the health plan in the form of a contract amendment. The state agency will ensure that any program changes resulting in changes to rate will be done in an actuarially sound manner.

2.34.5 The health plan shall guarantee and certify that no State of Missouri legislator or State of Missouri employee holds a controlling interest in the health plan.

2.34.6 The health plan shall understand and agree that the State of Missouri (its departments and employees) does not maintain commercial liability insurance.

2.34.7 Members are the intended beneficiaries of the contracts and as such are entitled to the remedies accorded to third party beneficiaries under the law.

2.34.8 The health plan is prohibited from using MO HealthNet Managed Care funds for services provided in the following circumstances:

a. Items or services provided by any financial institution or entity located outside the United States;

b. Non-emergency services provided by or under the direction of an excluded individual;

c. Any funds not used under the Assisted Suicide Funding Restriction Act of 1997; and

d. Any amount expended for roads, bridges, stadiums, or any other item.

2.34.9 The Missouri Department of Insurance, Financial Institutions & Professional Registration regulates the health plans licensed in Missouri including their financial stability. Therefore, the health plan shall comply with all Department of Insurance, Financial Institutions & Professional Registration applicable standards.

2.35 Actions Upon Expiration, Termination, or Cancelation of Contract:

2.35.1 Expiration, termination, or cancellation of the contract does not eliminate the health plan's responsibility to the state agency for overpayments made to the health plan. Upon expiration, termination, or cancelation of the contract, the health plan shall return to the state agency any payments advanced to the health plan for coverage of members for periods after the date of contract expiration, termination, or

cancellation. The health plan shall return such payments to the state agency within ninety (90) calendar days of contract expiration/termination/cancellation.

2.35.2 Upon expiration, termination, or cancelation of the contract, the health plan shall promptly supply all information necessary for the reimbursement of any outstanding claims.

2.35.3 In the event the contract is canceled, the state agency shall notify all members of the date of cancellation and process by which the members will continue to receive contract services and the health plan shall be responsible for all expenses related to said notification under these circumstances. In the event the contract is terminated by mutual consent, the state agency shall notify all members of the date of termination and process by which the members will continue to receive contract services; and the state agency shall be responsible for all expenses relating to said notification.

2.35.4 In addition, for three hundred sixty-five (365) calendar days after expiration, termination, or cancellation of the contract, the health plan shall continue providing those administrative functions that cannot be completed prior to the expiration, termination, or cancellation of the contract due to the nature of the function. Such administrative functions, shall include, but are not limited to, the requirements specified with Payments to Providers related to the payment of claims for service dates prior to the expiration, termination, or cancellation of the contract; Member Services System; Provider Complaints and Appeals; Operational Data Reporting; Financial Reporting; and communication links with the state agency.

a. Upon expiration, termination, or cancelation of the contract, the state agency will withhold thirty percent (30%) of the last month's capitation payment due to the health plan. Once the state agency determines that the health plan has substantially complied with administrative functions specified above, the withheld portion of the capitation will be paid to the health plan. The contractor's failure to comply with such administrative functions shall result in the contractor's forfeiture of the 30% withhold, or a portion thereof.

2.36 Sexual Harassment Policy: The health plan shall have a written policy regarding the illegality of sexual harassment. At a minimum, the policy shall include:

a. The definition of sexual harassment under Federal and State law, as amended;

b. The health plan's internal complaint process including penalties;

c. The legal recourse, investigative, and complaint process available for members through the state agency and for employees through the Missouri Commission on Human Rights; and

d. Instructions on how to contact the state agency and the Missouri Commission on Human Rights.

2.37 Payment Requirements: On a monthly basis, as near as practical to the fifth day of the calendar month following the month for which services have been performed and for which payment is being made, the state agency shall make payments to the health plan via electronic funds transfer in accordance with the following:

2.37.1 For each member enrolled on the first of the month, the state agency shall pay the health plan the firm, fixed per member, per month base capitation rate specified on the specific region's Pricing Page for the Category of Aid Rate Subgroup for the member. Effective January 1, 2013, the per member, per month base capitation rate reflects any upward or downward adjustment due to the health plan's budget neutral case mix factor as determined by the risk adjustment process.

a. The state agency shall pro-rate the base capitation rate when the member's birth date necessitates a change to a different Category of Aid or Rate Subgroup in a given month.

b. For members enrolled at any time after the beginning of the month's payment cycle, the state agency shall pro-rate the base capitation rate for the first partial month.

c. For members whose enrollment lapses for any period of a month in which a capitation payment was made due to loss of eligibility, death, or other circumstance, the state agency shall adjust its next monthly capitation payment to recoup the portion of the capitation payment to which it is due a refund.

d. Any payment pro-rations shall be on a daily basis.

2.37.2 In addition to the base capitation payment specified above, after receipt of encounter data from the health plan, the state agency shall make a one-time supplemental payment for the following events:

a. Following deliveries, the state agency shall make a one-time delivery event payment to the health plan in the amount specified on the Pricing Pages for a member where a delivery has occurred. The one-time delivery event payment shall constitute the health plan's total reimbursement for all delivery-related services provided to the mother during her associated hospital admission. Multiple births shall constitute one (1) delivery. Monthly capitation payments will continue to be paid for pregnant women during their pregnancy.

b. Following a birth of a low birth weight newborn, the state agency shall make a neonatal intensive care unit (NICU) payment to the health plan in the amount specified on the Pricing Pages for a member where a very low birth rate newborn has been documented. The NICU payment shall constitute the health plan's total reimbursement for the additional risk associated with the low birth weight newborn during the first year of life not already reimbursed through the per member, per month capitation payment.

2.37.3 The health plan shall accept capitation payments as specified herein and shall have and implement written policies and procedures for receiving and processing the capitation payments.

2.37.4 The health plan shall agree and understand that the capitation and supplemental payments specified herein shall be the only payments made to the health plan for all services required herein and that no other payment or reimbursement for any reason whatsoever shall be made to the health plan. In exchange for the capitation and supplemental payments, the health plan shall be liable or "at risk" for the costs of all covered services.

2.37.5 In the event that the Missouri General Assembly appropriates funds expressly for the services required herein, the State of Missouri shall amend the contract. In such event, the health plan shall pass fee increases to its providers commensurate with the Missouri General Assembly's intent. It must clearly be the intent of the Missouri General Assembly that increases be added during an ongoing contract period for any such amendment to take place.

2.37.6 Except for monies received from the collection of third-party liabilities, the only source of payment to the health plan for the services provided hereunder is from funds under the control of the state agency. An error discovered by the State, in the amount of fees paid to the health plan, with or without an audit, will be subject to adjustment or repayment by the state agency via a recoupment from future payment(s) to the health plan, or by making an additional payment to the health plan. When the health plan identifies an overpayment, the state agency must be notified and reimbursed within thirty (30) days of identification. No payment due the health plan by the state agency may be assigned or pledged by the health plan. This section shall not prohibit the state agency at its sole option from making payment to a fiscal agent hired by the health plan.

2.37.7 **Health Insurer Fee**:

a. Section 9010 of the Patient Protection and Affordable Care Act of 2010 Pub. L. No. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (124 Stat. 1029 (2010)) imposes an annual fee on health insurance providers, including the health plan, beginning January 2014 ("Annual Fee").

b. The state agency shall reimburse the health plan for the Annual Fee which the health plan incurs and becomes obligated to pay due to its receipt of capitation payments pursuant to the contract for each calendar year or part thereof, including an adjustment for the impact of non-deductibility of the Annual Fee for Federal and state tax purposes, including income and excise taxes ("Health Plan's Adjusted Fee"). The Health Plan's Adjusted Fee is included in the capitation rates payable to the health plan under the contract.

c. Because of the initial uncertainty of the actual amount of the Health Plan's Adjusted Fee, the state agency will determine an estimated monthly adjustment to the capitation payment paid during the year payment is due to the IRS (the "Fee Year") to reflect the estimated amount of the Health Plan's Adjusted Fee, allocated on a monthly basis. If available, such estimate shall consider the pro rata share of the preliminary notice of the fee amount and annual fee amounts thereafter, as transmitted by the United States Internal Revenue Service to the health plans in the MO HealthNet Managed Care Program, attributable to the MO HealthNet Managed Care Health Plans' net written capitation payments under the contract during the preceding calendar year (the "Data Year").

d. The health plan must submit a certified copy of its full Annual Fee assessment within 45 days of receipt, together with the allocation of the Annual Fee attributable specifically to its capitation payments under the contract. The health plan must also submit the calculated adjustment for the impact of non-deductibility of the Annual Fee attributable specifically to its capitation payments under the contract, and any other data deemed necessary by the state agency to validate the reimbursement amount. These materials shall be submitted under the signatures of either the health plan's Financial Officer or Executive leadership (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the data provided. The health plan shall indicate for the state agency the portion of the MO HealthNet Managed Care Program capitation payments that was excluded from the Form 8963 payments by the health plan as long-term care.

e. Following the receipt of the final notice of the fee from the United States Internal Revenue Service and the health plan's allocation of the Annual Fee attributable to the contract and approval of the allocation by the state agency, the Health Plan's Adjusted Fee will be modified based on the difference between the Annual Fee and the amounts paid (or to be paid) during the Calendar Year through the health plan's capitation, delivery, NICU, and high risk claims pool payments. Capitation payments will be revised, as necessary, no later than the March following the Fee Year to reflect the Health Plan's Adjusted Fee in the Fee Year. The health plan shall reimburse the state agency for any amount applicable to MO HealthNet Managed Care capitation payments that are not paid towards the fee and/or are reimbursed to the health plan, at any time and for any reason, by the IRS.

f. The final amount to be included in health plan's capitation payments for each contract period shall be calculated from the final notification of fee amount the health plan receives from the United States Internal Revenue Service in consideration of the allocation of the Annual Fee attributable to the contract, and shall recognize the impact on the health plan associated with the non-deductibility of the fee for Federal and state tax purposes.

2.38 Business Associate Provisions:

2.38.1 Health Insurance Portability and Accountability Act of 1996, as amended - The state agency and the contractor are both subject to and must comply with provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH) (PL-111-5) (collectively, and hereinafter, HIPAA) and all regulations promulgated pursuant to authority granted therein. The contractor constitutes a "Business Associate" of the state agency. Therefore, the term, "contractor" as used in this section shall mean "Business Associate."

a. The contractor agrees that for purposes of the Business Associate Provisions contained herein, terms used but not otherwise defined shall have the same meaning as those terms defined in 45 CFR Parts 160 and 164 and 42 U.S.C. §§ 17921 *et. seq.* including, but not limited to the following:

1) "Access", "administrative safeguards", "confidentiality", "covered entity", "data aggregation", "designated record set", "disclosure", "hybrid entity", "information system", "physical safeguards", "required by law", "technical safeguards", "use" and "workforce" shall have the same meanings as defined in 45 CFR 160.103, 164.103, 164.304, and 164.501 and HIPAA.

2) "Breach" shall mean the unauthorized acquisition, access, use, or disclosure of Protected Health Information which compromises the security or privacy of such information, except as provided in 42 U.S.C. § 17921. This definition shall not apply to the term "breach of contract" as used within the contract.

3) "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean the contractor.

4) "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean the state agency.

5) "Electronic Protected Health Information" shall mean information that comes within paragraphs (1)(i) or (1)(ii) of the definition of Protected Health Information as specified below.

6) "Enforcement Rule" shall mean the HIPAA Administrative Simplification: Enforcement; Final Rule at 45 CFR Parts 160 and 164.

7) "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

8) "Individual" shall have the same meaning as the term "individual" in 45 CFR 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502 (g).

9) "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

10) "Protected Health Information" as defined in 45 CFR 160.103, shall mean individually identifiable health information:

- (a) Except as provided in paragraph (b) of this definition, that is: (i) Transmitted by electronic media; or (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.
- (b) Protected Health Information excludes individually identifiable health information in (i) Education records covered by the Family Educational Rights and Privacy Act, as amended,

20 U.S.C. 1232g; (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) Employment records held by a covered entity (state agency) in its role as employer.

11) "Security Incident" shall be defined as set forth in the "Obligations of the Contractor" section of the Business Associate Provisions.

12) "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C.

13) "Unsecured Protected Health Information" shall mean Protected Health Information that is not secured through the use of a technology or methodology determined in accordance with 42 U.S.C. § 17932 or as otherwise specified by the secretary of Health and Human Services.

b. The contractor agrees and understands that wherever in this document the term Protected Health Information is used, it shall also be deemed to include Electronic Protected Health Information.

c. The contractor must appropriately safeguard Protected Health Information which the contractor receives from or creates or receives on behalf of the state agency. To provide reasonable assurance of appropriate safeguards, the contractor shall comply with the business associate provisions stated herein, as well as the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH) (PL-111-5) and all regulations promulgated pursuant to authority granted therein.

d. The state agency and the contractor agree to amend the contract as is necessary for the parties to comply with the requirements of HIPAA and the Privacy Rule, Security Rule, Enforcement Rule, and other rules as later promulgated (hereinafter referenced as the regulations promulgated thereunder). Any ambiguity in the contract shall be interpreted to permit compliance with the HIPAA Rules.

2.38.2 Permitted Uses and Disclosures of Protected Health Information by the Contractor:

a. The contractor may not use or disclose Protected Health Information in any manner that would violate Subpart E of 45 CFR Part 164 if done by the state agency, except for the specific uses and disclosures in the contract.

b. The contractor may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, the state agency as specified in the contract, provided that such use or disclosure would not violate HIPAA and the regulations promulgated thereunder.

c. The contractor may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j)(1) and shall notify the state agency by no later than ten (10) calendar days after the contractor becomes aware of the disclosure of the Protected Health Information.

d. If required to properly perform the contract and subject to the terms of the contract, the contractor may use or disclose Protected Health Information if necessary for the proper management and administration of the contractor's business.

e. If the disclosure is required by law, the contractor may disclose Protected Health Information to carry out the legal responsibilities of the contractor.

f. If applicable, the contractor may use Protected Health Information to provide Data Aggregation services to the state agency as permitted by 45 CFR 164.504(e)(2)(i)(B).

g. The contractor may not use Protected Health Information to de-identify or re-identify the information in accordance with 45 CFR 164.514(a)-(c) without specific written permission from the state agency to do so.

h. The contractor agrees to make uses and disclosures and requests for Protected Health Information consistent with the state agency's minimum necessary policies and procedures.

2.38.3 Obligations and Activities of the Contractor:

a. The contractor shall not use or disclose Protected Health Information other than as permitted or required by the contract or as otherwise required by law, and shall comply with the minimum necessary disclosure requirements set forth in 45 CFR § 164.502(b).

b. The contractor shall use appropriate administrative, physical and technical safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by the contract. Such safeguards shall include, but not be limited to:

1) Workforce training on the appropriate uses and disclosures of Protected Health Information pursuant to the terms of the contract;

2) Policies and procedures implemented by the contractor to prevent inappropriate uses and disclosures of Protected Health Information by its workforce and subcontractors, if applicable;

3) Encryption of any portable device used to access or maintain Protected Health Information or use of equivalent safeguard;

4) Encryption of any transmission of electronic communication containing Protected Health Information or use of equivalent safeguard; and

5) Any other safeguards necessary to prevent the inappropriate use or disclosure of Protected Health Information.

c. With respect to Electronic Protected Health Information, the contractor shall use appropriate administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that contractor creates, receives, maintains or transmits on behalf of the state agency and comply with Subpart C of 45 CFR Part 164, to prevent use or disclosure of Protected Health Information other than as provided for by the contract.

d. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), the contractor shall require that any agent or subcontractor that creates, receives, maintains, or transmits Protected Health Information on behalf of the contractor agrees to the same restrictions, conditions, and requirements that apply to the contractor with respect to such information.

e. By no later than ten (10) calendar days after receipt of a written request from the state agency, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, the contractor shall make the contractor's internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, created by, or received by the contractor on behalf of the state agency available to the state agency and/or to the Secretary of the Department of Health and Human Services or designee for purposes of determining compliance with the HIPAA Rules and the contract.

f. The contractor shall document any disclosures and information related to such disclosures of Protected Health Information as would be required for the state agency to respond to a request by an

individual for an accounting of disclosures of Protected Health Information in accordance with 42 USCA §17932 and 45 CFR 164.528. By no later than five (5) calendar days of receipt of a written request from the state agency, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, the contractor shall provide an accounting of disclosures of Protected Health Information regarding an individual to the state agency. If requested by the state agency or the individual, the contractor shall provide an accounting of disclosures directly to the individual. The contractor shall maintain a record of any accounting made directly to an individual at the individual's request and shall provide such record to the state agency upon request.

g. In order to meet the requirements under 45 CFR 164.524, regarding an individual's right of access, the contractor shall, within five (5) calendar days following a state agency request, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, provide the state agency access to the Protected Health Information in an individual's designated record set. However, if requested by the state agency, the contractor shall provide access to the Protected Health Information in a designated record set directly to the individual for whom such information relates.

h. At the direction of the state agency, the contractor shall promptly make any amendment(s) to Protected Health Information in a Designated Record Set pursuant to 45 CFR 164.526.

i. The contractor shall report to the state agency's Security Officer any security incident immediately upon becoming aware of such incident and shall take immediate action to stop the continuation of any such incident. For purposes of this paragraph, security incident shall mean the attempted or successful unauthorized access, use, modification or destruction of information or interference with systems operations in an information system. This does not include trivial incidents that occur on a daily basis, such as scans, "pings," or unsuccessful attempts that do not penetrate computer networks or servers or result in interference with system operations. By no later than five (5) days after the contractor becomes aware of such incident, the contractor shall provide the state agency's Security Officer with a description of any remedial action taken to mitigate any harmful effect of such incident and a proposed written plan of action for approval that describes plans for preventing any such future security incidents.

j. The contractor shall report to the state agency's Privacy Officer any unauthorized use or disclosure of Protected Health Information not permitted or required as stated herein immediately upon becoming aware of such use or disclosure and shall take immediate action to stop the unauthorized use or disclosure. By no later than five (5) calendar days after the contractor becomes aware of any such use or disclosure, the contractor shall provide the state agency's Privacy Officer with a written description of any remedial action taken to mitigate any harmful effect of such disclosure and a proposed written plan of action for approval that describes plans for preventing any such future unauthorized uses or disclosures.

k. The contractor shall report to the state agency's Security Officer any breach immediately upon becoming aware of such incident and shall take immediate action to stop the continuation of any such incident. By no later than five (5) days after the contractor becomes aware of such incident, the contractor shall provide the state agency's Security Officer with a description of the breach, the information compromised by the breach, and any remedial action taken to mitigate any harmful effect of such incident and a proposed written plan for approval that describes plans for preventing any such future incidents.

l. The contractor's reports required in the preceding paragraphs shall include the following information regarding the security incident, improper disclosure/use, or breach, (hereinafter "incident"):

1) The name, address, and telephone number of each individual whose information was involved if such information is maintained by the contractor;

2) The electronic address of any individual who has specified a preference of contact by electronic mail;

3) A brief description of what happened, including the date(s) of the incident and the date(s) of the discovery of the incident;

4) A description of the types of Protected Health Information involved in the incident (such as full name, Social Security Number, date of birth, home address, account number, or disability code) and whether the incident involved Unsecured Protected Health Information; and

5) The recommended steps individuals should take to protect themselves from potential harm resulting from the incident.

m. Notwithstanding any provisions of the Terms and Conditions attached hereto, in order to meet the requirements under HIPAA and the regulations promulgated thereunder, the contractor shall keep and retain adequate, accurate, and complete records of the documentation required under these provisions for a minimum of six (6) years as specified in 45 CFR Part 164.

n. Contractor shall not directly or indirectly receive remuneration in exchange for any Protected Health Information without a valid authorization.

o. If the contractor becomes aware of a pattern of activity or practice of the state agency that constitutes a material breach of contract regarding the state agency's obligations under the Business Associate Provisions of the contract, the contractor shall notify the state agency's Security Officer of the activity or practice and work with the state agency to correct the breach of contract.

p. The contractor shall indemnify the state agency from any liability resulting from any violation of the Privacy Rule or Security Rule or Breach arising from the conduct or omission of the contractor or its employee(s), agent(s) or subcontractor(s). The contractor shall reimburse the state agency for any and all actual and direct costs and/or losses, including those incurred under the civil penalties implemented by legal requirements, including but not limited to HIPAA as amended by the Health Information Technology for Economic and Clinical Health Act, and including reasonable attorney's fees, which may be imposed upon the state agency under legal requirements, including but not limited to HIPAA's Administrative Simplification Rules, arising from or in connection with the contractor's negligent or wrongful actions or inactions or violations of this Agreement.

2.38.4 Obligations of the State Agency:

a. The state agency shall notify the contractor of limitation(s) that may affect the contractor's use or disclosure of Protected Health Information, by providing the contractor with the state agency's notice of privacy practices in accordance with 45 CFR 164.520.

b. The state agency shall notify the contractor of any changes in, or revocation of, authorization by an Individual to use or disclose Protected Health Information.

c. The state agency shall notify the contractor of any restriction to the use or disclosure of Protected Health Information that the state agency has agreed to in accordance with 45 CFR 164.522.

d. The state agency shall not request the contractor to use or disclose Protected Health Information in any manner that would not be permissible under HIPAA and the regulations promulgated thereunder.

2.38.5 Expiration/Termination/Cancellation - Except as provided in the subparagraph below, upon the expiration, termination, or cancellation of the contract for any reason, the contractor shall, at the

discretion of the state agency, either return to the state agency or destroy all Protected Health Information received by the contractor from the state agency, or created or received by the contractor on behalf of the state agency, and shall not retain any copies of such Protected Health Information. This provision shall also apply to Protected Health Information that is in the possession of subcontractor or agents of the contractor.

a. In the event the state agency determines that returning or destroying the Protected Health Information is not feasible, the contractor shall extend the protections of the contract to the Protected Health Information for as long as the contractor maintains the Protected Health Information and shall limit the use and disclosure of the Protected Health Information to those purposes that made return or destruction of the information infeasible. If at any time it becomes feasible to return or destroy any such Protected Health Information maintained pursuant to this paragraph, the contractor must notify the state agency and obtain instructions from the state agency for either the return or destruction of the Protected Health Information.

2.38.6 Breach of Contract – In the event the contractor is in breach of contract with regard to the business associate provisions included herein, the contractor agrees that in addition to the requirements of the contract related to cancellation of contract, if the state agency determines that cancellation of the contract is not feasible, the State of Missouri may elect not to cancel the contract, but the state agency shall report the breach of contract to the Secretary of the Department of Health and Human Services.

3. GENERAL CONTRACTUAL REQUIREMENTS:

3.1 Contract - A binding contract shall consist of: (1) the RFP, amendments thereto, and any Best and Final Offer (BAFO) request(s) with RFP changes/additions, (2) the health plan's proposal including any BAFO response(s), (3) clarification of the proposal, if any, and (4) the Division of Purchasing and Materials Management's acceptance of the proposal by "notice of award". All Exhibits and Attachments included in the RFP shall be incorporated into the contract by reference.

3.1.1 A notice of award issued by the State of Missouri does not constitute an authorization for shipment of equipment or supplies or a directive to proceed with services. Before providing equipment, supplies and/or services for the State of Missouri, the health plan must receive a properly authorized purchase order or other form of authorization given to the health plan at the discretion of the state agency.

3.1.2 The contract expresses the complete agreement of the parties and performance shall be governed solely by the specifications and requirements contained therein.

3.1.3 Any change to the contract, whether by modification and/or supplementation, must be accomplished by a formal contract amendment signed and approved by and between the duly authorized representative of the health plan and the Division of Purchasing and Materials Management prior to the effective date of such modification. The health plan expressly and explicitly understands and agrees that no other method and/or no other document, including correspondence, acts, and oral communications by or from any person, shall be used or construed as an amendment or modification to the contract.

a. In the event that changes in federal or state law require the Division of Purchasing and Materials Management to modify the contract, when deemed appropriate a written amendment will be issued to the health plan.

b. The terms of the contract and any amendment thereto must receive the approval of the United States Department of Health and Human Services. The United States Department of Health and Human Services failure to approve a provision of the contract shall render the provision null and void.

3.2 Contract Period - The original contract period shall be as stated on page 1 of the Request for Proposal (RFP). The contract shall not bind, nor purport to bind, the state for any contractual commitment in excess of the original contract period. The Division of Purchasing and Materials Management shall have the right, at its sole option, to renew the contract for two (2) additional one-year periods, or any portion thereof. In the event the Division of Purchasing and Materials Management exercises such right, all terms and conditions, requirements and specifications of the contract shall remain the same and apply during the renewal period, pursuant to the following:

3.2.1 The state agency will include in each year's budget request to the Office of Administration, Division of Budget and Planning, a rate change based on the state agency's review of recent health plan financial experience and medical trends from other state Medicaid programs and national trend indices (CPI/DRI). The rate changes will be reflective of anticipated programmatic changes.

3.2.2 If the State of Missouri elects to renew the contract for the first and second renewal option, the health plan shall accept the amount appropriated by the Governor and the Missouri General Assembly within the actuarially sound capitation rates required by 42 CFR 438.6(c) to be paid on a risk-based, capitated rate basis. Rates will be actuarially determined prior to the contract renewal period.

3.2.3 The State of Missouri reserves the right to extend the contract for a period less than the length of the above-referenced renewal period if such an extension is determined by the state agency to be in the best interest of the State.

3.2.4 During the second and final renewal option, the State of Missouri may issue a public notice of the pending contract expiration and the upcoming opportunity to contract with the State of Missouri for MO

HealthNet Managed Care services. If no health plans, other than the health plans the State of Missouri currently contracts with, indicate interest in contracting with the State of Missouri for such, the State of Missouri may elect to renew the contract with the health plan for the continuation of the MO HealthNet Managed Care services.

3.3 **Price:** All prices shall be as indicated on the Pricing Page. The state shall not pay nor be liable for any other additional costs including but not limited to taxes, shipping charges, insurance, interest, penalties, termination payments, attorney fees, liquidated damages, etc.

3.4 **Termination -** The Division of Purchasing and Materials Management reserves the right to terminate the contract at any time, for the convenience of the State of Missouri, without penalty or recourse, by giving written notice to the health plan at least thirty (30) calendar days prior to the effective date of such termination. In the event of termination pursuant to this paragraph, all documents, data, reports, supplies, equipment, and accomplishments prepared, furnished or completed by the health plan pursuant to the terms of the contract shall, at the option of the Division of Purchasing and Materials Management, become the property of the State of Missouri. The health plan shall be entitled to receive compensation for services and/or supplies delivered to and accepted by the State of Missouri pursuant to the contract prior to the effective date of termination.

3.5 **Force Majeure -** The health plan shall not be liable for any excess costs for delayed delivery of goods or services to the State of Missouri, if the failure to perform the contract arises out of causes beyond the control of, and without the fault or negligence of the health plan. Such causes may include, however are not restricted to: acts of God, fires, floods, epidemics, quarantine restrictions, strikes, and freight embargoes. In all cases, the failure to perform must be beyond the control of, and without the fault or negligence of, either the health plan or any subcontractor(s). The health plan shall take all possible steps to recover from any such occurrences.

3.6 **Transition:** Upon expiration, termination, or cancellation of the contract, the health plan shall assist the state agency to ensure an orderly and smooth transfer of responsibility and continuity of those services required under the terms of the contract to an organization designated by the state agency. If requested by the state agency, the health plan shall provide and/or perform any or all of the following responsibilities:

3.6.1 If notified by a formal contract amendment from the Division of Purchasing and Materials Management, the health plan shall continue providing any part or all of the services in accordance with the terms and conditions, requirements and specifications of the contract for a period not to exceed ninety (90) calendar days after the expiration, termination, or cancellation of the contract for a price not to exceed those prices set forth in the contract.

3.6.2 The health plan shall deliver, FOB destination, all records, documentation, reports, data, recommendations, or printing elements, etc., which were required to be produced under the terms of the contract to the state agency and/or to the state agency's designee within thirty (30) days after receipt of the written request in a format and condition that are acceptable to the state agency.

3.6.3 The state agency, at its sole option, may discontinue enrolling new membership to the health plan, on a date specified by the state agency, prior to expiration, cancellation, or termination of the contract.

3.7 **Health Plan Liability -** The health plan shall be responsible for any and all personal injury (including death) or property damage as a result of the health plan's negligence involving any equipment or service provided under the terms and conditions, requirements and specifications of the contract. In addition, the health plan assumes the obligation to save the State of Missouri, including its agencies, employees, and assignees, from every expense, liability, or payment arising out of such negligent act.

3.7.1 The health plan also agrees to hold the State of Missouri, including its agencies, employees, and assignees, harmless for any negligent act or omission committed by any subcontractor or other person employed by or under the supervision of the health plan under the terms of the contract.

3.7.2 The health plan shall not be responsible for any injury or damage occurring as a result of any negligent act or omission committed by the State of Missouri, including its agencies, employees, and assignees.

3.7.3 Under no circumstances shall the health plan be liable for any of the following: (1) third party claims against the state for losses or damages (other than those listed above); or (2) economic consequential damages (including lost profits or savings) or incidental damages, even if the health plan is informed of their possibility.

3.8 Insurance - The health plan shall understand and agree that the State of Missouri cannot save and hold harmless and/or indemnify the health plan or employees against any liability incurred or arising as a result of any activity of the health plan or any activity of the health plan's employees related to the health plan's performance under the contract. Therefore, the health plan shall maintain adequate liability insurance in the form(s) and amount(s) sufficient to protect the State of Missouri, its agencies, its employees, its clients, and the general public against any loss, damage, and/or expense related to his/her performance under the contract.

3.8.1 The insurance coverage shall include, but shall not necessarily be limited to, general liability, professional liability, etc. In addition, automobile liability coverage for the operation of any motor vehicle must be maintained if the terms of the contract require any form of transportation services. The limits of liability for all types of coverage shall not be less than $2,000,000 per occurrence. The general and other non-professional liability insurance shall include an endorsement that adds the State of Missouri as an additional insured.

3.8.2 The health plan shall provide written evidence of the insurance to the state agency prior to performance under the contract. Such evidence shall include, but shall not necessarily be limited to: effective dates of coverage, limits of liability, insurer's name, policy number, endorsement for the non-professional liability insurance naming the State of Missouri as an additional insured, endorsement by representatives of the insurance company, etc. The contract number must be identified on the evidence of insurance coverage. Evidence of self-insurance coverage or of another alternate risk financing mechanism may be utilized provided that such coverage is verifiable and irrevocably reliable and the State of Missouri is protected as an additional insured.

3.8.3 In the event the insurance coverage is canceled, the state agency must be notified within thirty (30) calendar days.

3.9 Subcontractors - Any subcontracts for the products/services described herein must include appropriate provisions and contractual obligations to ensure the successful fulfillment of all contractual obligations agreed to by the health plan and the State of Missouri and to ensure that the State of Missouri is indemnified, saved, and held harmless from and against any and all claims of damage, loss, and cost (including attorney fees) of any kind related to a subcontract in those matters described in the contract between the State of Missouri and the health plan.

3.9.1 Health Plan Disputes With Other Providers: All disputes between the health plan and any subcontractors, shall be solely between such subcontractors and the health plan. The health plan shall indemnify, defend, save, and hold harmless the State of Missouri, the Department of Social Services and its officers, employees, and agents, and enrolled MO HealthNet Managed Care members from any and all actions, claims, demands, damages, liabilities, or suits of any nature whatsoever arising out of the contract because of any breach of the contract by the health plan, its subcontractors, agents, providers, or employees, including but not limited to any negligent or wrongful acts, occurrence or omission of commission, or negligence of the health plan, its subcontractors, agents, providers, or employees.

3.9.2 The health plan shall expressly understand and agree that the health plan shall assume and be solely responsible for all legal and financial responsibilities related to the execution of a subcontract.

3.9.3 The health plan shall agree and understand that utilization of a subcontractor to provide any of the products/services in the contract shall in no way relieve the health plan of the responsibility for providing the products/services as described and set forth herein.

3.9.4 The health plan must obtain the approval of the State of Missouri prior to establishing any new subcontracting arrangements and before changing any subcontractors. The approval shall not be arbitrarily withheld.

3.9.5 Pursuant to subsection 1 of section 285.530, RSMo, no contractor or subcontractor shall knowingly employ, hire for employment, or continue to employ an unauthorized alien to perform work within the state of Missouri. In accordance with sections 285.525 to 285.550, RSMo, a general contractor or subcontractor of any tier shall not be liable when such contractor or subcontractor contracts with its direct subcontractor who violates subsection 1 of section 285.530, RSMo, if the contract binding the contractor and subcontractor affirmatively states that:

a. The direct subcontractor is not knowingly in violation of subsection 1 of section 285.530, RSMo, and shall not henceforth be in such violation.
b. The contractor or subcontractor receives a sworn affidavit under the penalty of perjury attesting to the fact that the direct subcontractor's employees are lawfully present in the United States.

3.9.6 All subcontracts for health care services must be in writing and shall comply with all provisions of the contract and shall include at least the items listed below. In addition, all subcontractors shall comply with the applicable provisions of Federal and State laws and regulations, as amended, and policies. Before any delegation of any functions and responsibilities to any subcontractor, the health plan shall evaluate the prospective subcontractor's ability to perform the activities to be delegated. The health plan shall have policies and procedures to monitor the performance of health care service subcontractors to ensure that such subcontractors comply with the provisions of the contract. In addition, the health plan shall fully investigate and timely respond to issues involving subcontractors upon request of the state agency.

a. A description of services to be provided or other activities performed. This description shall be in such form as to permit the state agency to ascertain definitively which contractual obligations have been subcontracted.

b. The timeframes for paying in-network providers for covered services.

c. Provision(s) for release to the health plan of any information necessary for the health plan to perform any of its obligations under the contract including but not limited to compliance with all reporting requirements (for example encounter data reporting requirements), timely payment requirements, and quality assessment requirements.

d. The provision available to a health care provider to challenge or appeal the failure of the health plan to cover a service.

e. Provision(s) that (1) the subcontractor's facilities and records shall be open to inspection by the health plan and appropriate Federal and state agencies, and (2) the medical records, or copies thereof, shall be provided to the health plan, upon request, for transfer to subsequent subcontractors for review by the state agency.

f. Provisions that require each health care provider to maintain comprehensive medical records for a minimum of five years.

g. A provision that ensures that subcontractors accept payment from the health plan as payment in full (no balance billing) and not collect payment from members.

h. Provision(s) that prohibit any financial incentive arrangement to induce subcontractors to limit medically necessary services. A description of all financial incentive arrangements shall be included in the subcontract. In the event of a change to these financial incentive arrangements, the subcontractor shall immediately notify the health plan of such change so the health plan can meet its requirement to notify the state agency.

i. Provisions that the health plan may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient:

1) For the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

2) For any information the member needs in order to decide among all relevant treatment options.

3) For the risks, benefits, and consequences of treatment or non-treatment.

4) For the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

j. Provisions that subcontractors shall not conduct or participate in health plan enrollment, disenrollment, transfer, or opt out activities. The subcontractors shall not influence a member's enrollment. Prohibited activities include:

1) Requiring or encouraging the member to apply for an assistance category not included in MO HealthNet Managed Care;

2) Requiring or encouraging the member and/or guardian to use the opt out provision as an option in lieu of delivering health plan benefits;

3) Mailing or faxing health plan enrollment forms;

4) Aiding the member in filling out health plan enrollment forms;

5) Photocopying blank health plan enrollment forms for potential members;

6) Distributing blank health plan enrollment forms;

7) Participating in three way calls to the MO HealthNet Managed Care enrollment helpline;

8) Suggesting a member transfer to another health plan; or

9) Other activities in which subcontractors are engaged in to enroll a member in a particular health plan or in any way assisting a member to enroll in a health plan.

k. If a subcontract is with a federally qualified health center (FQHC) or rural health clinic (RHC) to provide services to members under a prepayment arrangement, a provision that the state agency shall reimburse the FQHC or RHC one hundred percent (100%) of its reasonable cost for covered services.

l. All hospital subcontracts must require that the hospital subcontractor notify the health plan of births where the mother is a member. The subcontracts must specify which entity is responsible for notifying the Family Support Division of the birth.

m. For contracted services, the subcontractor shall follow the claim processing requirements set forth by RSMo 376.383 and 376.384, as amended.

n. Provisions in accordance with Federal and State laws and regulations, as amended, and policy regarding termination of the subcontract between the health plan and the subcontractor.

o. Provisions that in the event of the subcontractor's insolvency or other cessation of operations, covered services to members shall continue through the period for which a capitation payment has been made to the health plan or until the member's discharge from an inpatient facility, whichever time is greater.

p. The health plan and its subcontractors shall establish reasonable timely filing requirements for claims to be filed by a provider for reimbursement. The subcontractor shall inform its provider network of the timely filing requirements.

   1) In the case of capitated arrangements with providers, the subcontractor shall establish reasonable reporting of encounters to the health plan in sufficient detail to meet the health plan's encounter data reporting requirements.

   2) In the case of services provided by out-of-network providers, the health plan shall comply with State law regarding timely filing requirements.

q. Provision for revoking the subcontract agreement or imposing other sanctions if the subcontractor's performance is inadequate.

r. The health plan shall agree and understand that consumer protection shall be integral to the MO HealthNet Managed Care Program. All contracts between the health plan and providers shall ensure that the provider complies with the consumer protection provisions outlined in the marketing guidelines.

s. Provision(s) that entitle each member to one free copy of his or her medical records annually. The fee for additional copies shall not exceed the actual cost of time and materials used to compile, copy, and furnish such records.

t. Provisions requiring the subcontractor to comply with all fraud, waste, and abuse provisions contained herein that are applicable to providers or other subcontractors.

u. Provisions requiring the subcontractor to screen its employees and subcontractors to determine whether any of them has been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Act); has failed to renew license or certification registration; has revoked professional license or certification; or has been terminated by the state agency. The subcontract shall require that the subcontractor consult the following databases to conduct the screening on at least a monthly basis: the List of Excluded Individuals /Entities (LEIE) and the Excluded Parties List System (EPLS). The LEIE is located at https://oig.hhs.gov/exclusions/exclusions_list.asp and the EPLS is located at https://www.sam.gov/portal/public/SAM/. The subcontract shall require that the subcontractor consult the following databases, per State and Federal requirements: the National Plan and Provider Enumeration System (NPPES) located online at https://nppes.cms.hhs.gov/NPPES/Welcome.do, the Missouri Professional Registration Boards website, and any such other databases as the state agency may prescribe. The subcontract agreement shall require the health plan to promptly report relevant information disclosed as a resulting of the screening process. The subcontract agreement shall require the subcontractor not to employ or contract with an individual or entity identified by an initial screening; and to terminate any current employee or subcontractor identified by a routine monthly screening.

v. Provisions requiring that subcontractors that are providers or benefit management organizations make disclosures to the health plan of full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the Federal Title XX programs in accordance with Federal and State requirements, including Public Chapter 379 of the Acts of 1999 and 42 CFR 455.104-106 and 42 CFR 1001.1001-1002.

1) For directly contracted providers, the subcontract shall require the disclosures to be provided:

- At the stage of credentialing and re-credentialing;
- Upon execution of the provider agreement;
- Within thirty-five (35) calendar days of any change in ownership of the provider; and
- At any time upon request by the state agency for any or all of the information described in herein.

2) For benefit management organizations, the subcontract shall require:

- That the benefit management organization provide the disclosures (concerning its own business) upon execution of its contract with the health plan, and within thirty-five (35) calendar days of any change in ownership of the organization;
- That the benefit management organization collect the disclosure information from its subcontracted providers:
  - At the stage of credentialing and re-credentialing;
  - Upon execution of the provider agreement with the benefit management organization;
  - Within thirty-five (35) calendar days of any change in ownership of the provider; and
  - At any time upon request by the state agency for any or all of the information described herein.
- That the benefit management organization shall promptly provide to the health plan the disclosures that it has collected from subcontracted providers.

w. Provisions requiring that subcontracted providers observe the following requirements:

1) Include the NPI of the ordering or referring physician or other professional with each claim for payment for services;

2) Implement a policy of, before providing a Medicaid service to a MO HealthNet adult member, requesting and inspecting the member's MO HealthNet identification card (or other documentation provided by the state agency demonstrating MO HealthNet eligibility) and health plan membership card; and

3) Report to the health plan any identified instance when the inspection discloses that the person seeking services is not a MO HealthNet Managed Care Program member.

x. Provisions specifying that no services under the subcontract may be performed outside the United States.

BAFO 001 REVISED THE FOLLOWING PARAGRAPH:

y. Provisions requiring that, at the time of execution of the subcontract, the subcontractor shall not knowingly utilize the services of an unauthorized alien to perform work under the subcontract. The health plan shall not knowingly utilize the services of any subcontractor who will utilize the services of an unauthorized alien.

3.10 Assignment -

3.10.1 The health plan shall not transfer any interest in the contract, whether by assignment or otherwise, without the prior written consent of the Division of Purchasing and Materials Management.

3.10.2 The health plan shall agree and understand that, in the event the Division of Purchasing and Materials Management consents to a financial assignment of the contract in whole or in part to a third party, any payments made by the State of Missouri pursuant to the contract, including all of those payments assigned to the third party, shall be contingent upon the performance of the prime contractor in accordance with all terms and conditions, requirements and specifications of the contract.

3.11 Substitution of Personnel - The health plan agrees and understands that the State of Missouri's agreement to the contract is predicated in part on the utilization of the specific key individual(s) and/or personnel qualifications identified in the proposal. Therefore, the health plan agrees and understands that any substitution of the specific key individual(s) and/or personnel qualifications identified in the proposal must be with individual(s) of equal or better qualifications than originally proposed.

3.12 Authorized Personnel:

3.12.1 The health plan shall only employ personnel authorized to work in the United States in accordance with applicable federal and state laws. This includes but is not limited to the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) and INA Section 274A.

3.12.2 If the health plan is found to be in violation of this requirement or the applicable state, federal and local laws and regulations, and if the State of Missouri has reasonable cause to believe that the health plan has knowingly employed individuals who are not eligible to work in the United States, the state shall have the right to cancel the contract immediately without penalty or recourse and suspend or debar the health plan from doing business with the state. The state may also withhold up to twenty-five percent of the total amount due to the health plan.

3.12.3 The health plan shall agree to fully cooperate with any audit or investigation from federal, state, or local law enforcement agencies.

3.12.4 If the health plan meets the definition of a business entity as defined in section 285.525, RSMo, pertaining to section 285.530, RSMo, the health plan shall maintain enrollment and participation in the E-Verify federal work authorization program with respect to the employees hired after enrollment in the program who are proposed to work in connection with the contracted services included herein. If the health plan's business status changes during the life of the contract to become a business entity as defined in section 285.525, RSMo, pertaining to section 285.530, RSMo, then the health plan shall, prior to the performance of any services as a business entity under the contract:

a. Enroll and participate in the E-Verify federal work authorization program with respect to the employees hired after enrollment in the program who are proposed to work in connection with the services required herein; AND
b. Provide to the Division of Purchasing and Materials Management the documentation required in the exhibit titled, Business Entity Certification, Enrollment Documentation, and Affidavit of Work Authorization affirming said company's/individual's enrollment and participation in the E-Verify federal work authorization program; AND

c. Submit to the Division of Purchasing and Materials Management a completed, notarized Affidavit of Work Authorization provided in the exhibit titled, Business Entity Certification, Enrollment Documentation, and Affidavit of Work Authorization.

3.12.5 In accordance with subsection 2 of section 285.530, RSMo, the health plan should renew their Affidavit of Work Authorization annually. A valid Affidavit of Work Authorization is necessary to award any new contracts.

3.13 Health Plan Status - The health plan is an independent contractor and shall not represent the health plan or the health plan's employees to be employees of the State of Missouri or an agency of the State of Missouri. The health plan shall assume all legal and financial responsibility for salaries, taxes, FICA, employee fringe benefits, workers compensation, employee insurance, minimum wage requirements, overtime, etc., and agrees to indemnify, save, and hold the State of Missouri, its officers, agents, and employees, harmless from and against, any and all loss; cost (including attorney fees); and damage of any kind related to such matters.

3.14 Coordination - The health plan shall fully coordinate all contract activities with those activities of the state agency. As the work of the health plan progresses, advice and information on matters covered by the contract shall be made available by the health plan to the state agency or the Division of Purchasing and Materials Management throughout the effective period of the contract.

3.15 Property of State - All documents, data, reports, supplies, equipment, and accomplishments prepared, furnished, or completed by the health plan pursuant to the terms of the contract shall become the property of the State of Missouri. Upon expiration, termination, or cancellation of the contract, said items shall become the property of the State of Missouri.

3.16 Confidentiality -

3.16.1 The health plan shall agree and understand that all discussions with the health plan and all information gained by the health plan as a result of the health plan's performance under the contract, including member information, medical records, data, and data elements established, collected, maintained, or used in the administration of the contract shall be confidential and that no reports, documentation, or material prepared as required by the contract shall be released to the public without the prior written consent of the state agency.

3.16.2 If required by the state agency, the health plan and any required health plan personnel must sign specific documents regarding confidentiality, security, or other similar documents upon request. Failure of the health plan and any required personnel to sign such documents shall be considered a breach of contract and subject to the cancellation provisions of this document

3.16.3 The health plan shall provide safeguards that restrict the use or disclosure of information concerning members to purposes directly connected with the administration of the contract.

3.16.4 The health plan shall not disclose the contents of member information or records to anyone other than the state agency, the member or the member's legal guardian, or other parties with the member's written consent.

3.16.5 In complying with the requirements of this section, the health plan and the state agency shall follow the requirements of 42 CFR Part 431, Subpart F, as amended, regarding confidentiality of information concerning applicants and members of public assistance and 42 CFR Part 2, as amended, regarding confidentiality of alcohol and drug abuse patient records.

3.16.6 The health plan shall have written policies and procedures for maintaining the confidentiality of data, including medical records, member information, and appointment records for adult and adolescent STDs and adolescent family planning services.

3.17 Performance Security Deposit - The health plan must furnish a performance security deposit in the form of an original bond issued by a surety company authorized to do business in the State of Missouri (no copy or facsimile is acceptable), check, cash, bank draft, or irrevocable letter of credit to the Office of Administration, Division of Purchasing and Materials Management within thirty (30) days after award of the contract and prior to performance of service under the contract.

3.17.1 The performance security deposit must be made payable to the State of Missouri in the amount of $3,000,000.00.

3.17.2 The contract number and contract period must be specified on the performance security deposit.

3.17.3 In the event the Division of Purchasing and Materials Management exercises an option to renew the contract for an additional period, the health plan shall maintain the validity and enforcement of the security deposit for the said period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of contract renewal.

3.17.4 Additionally, during the three hundred sixty-five (365) day transition period, the health plan shall maintain the validity and enforcement of the performance security deposit for performance of the administrative functions pursuant to the provisions of this paragraph, in an amount stipulated via written notification by the Division of Purchasing and Materials Management.

3.18 Participation by Other Organizations - The health plan must comply with any Organization for the Blind/Sheltered Workshop, Service-Disabled Veteran Business Enterprise (SDVE), and/or Minority Business Enterprise/Women Business Enterprise (MBE/WBE) participation levels committed to in the health plan's awarded proposal.

3.18.1 The health plan shall prepare and submit to the Division of Purchasing and Materials Management a report detailing all payments made by the health plan to Organizations for the Blind/Sheltered Workshops, SDVEs, and/or MBE/WBEs participating in the contract for the reporting period. The health plan must submit the report on a monthly basis, unless otherwise determined by the Division of Purchasing and Materials Management.

3.18.2 The Division of Purchasing and Materials Management will monitor the health plan's compliance in meeting the Organizations for the Blind/Sheltered Workshop and SDVE participation levels committed to in the health plan's awarded proposal. The Division of Purchasing and Materials Management in conjunction with the Office of Equal Opportunity (OEO) will monitor the health plan's compliance in meeting the MBE/WBE participation levels committed to in the health plan's awarded proposal. If the health plan's payments to the participating entities are less than the amount committed, the state may cancel the contract and/or suspend or debar the health plan from participating in future state procurements, or retain payments to the health plan in an amount equal to the value of the participation commitment less actual payments made by the health plan to the participating entity. If the Division of Purchasing and Materials Management determines that the health plan becomes compliant with the commitment, any funds retained as stated above, will be released.

3.18.3 If a participating entity fails to retain the required certification or is unable to satisfactorily perform, the health plan must obtain other certified MBE/WBEs or other organizations for the blind/sheltered workshops or other SDVEs to fulfill the participation requirements committed to in the health plan's awarded proposal.

a. The health plan must obtain the written approval of the Division of Purchasing and Materials Management for any new entities. This approval shall not be arbitrarily withheld.

b. If the health plan cannot obtain a replacement entity, the health plan must submit documentation to the Division of Purchasing and Materials Management detailing all efforts made to secure a

replacement. The Division of Purchasing and Materials Management shall have sole discretion in determining if the actions taken by the health plan constitute a good faith effort to secure the required participation and whether the contract will be amended to change the health plan's participation commitment.

3.18.4 No later than 30 days after the effective date of the first renewal period, the health plan must submit an affidavit to the Division of Purchasing and Materials Management. The affidavit must be signed by the director or manager of the participating Organizations for the Blind/Sheltered Workshop verifying provision of products and/or services and compliance of all health plan payments made to the Organizations for the Blind/Sheltered Workshops. The health plan may use the affidavit available on the Division of Purchasing and Materials Management's website at http://content.oa.mo.gov/sites/default/files/bswaffidavit.doc or another affidavit providing the same information.

3.19 Federal Funds Requirements - The health plan shall understand and agree that the contract may involve the use of federal funds. Therefore, for any federal funds used, the following paragraphs shall apply:

3.19.1 In performing its responsibilities under the contract, the health plan shall fully comply with the following Office of Management and Budget (OMB) administrative requirements and cost principles, as applicable, including any subsequent amendments:

a. Uniform Administrative Requirements - A-102 - State/Local Governments; 2 CFR 215 - Hospitals, Colleges and Universities, For-Profit Organizations (if specifically included in federal agency implementation), and Not-For-Profit Organizations (OMB Circular A-110).
b. Cost Principles - 2CFR 225 – State/Local Governments (OMB Circular A-87); A-122 - Not-For-Profit Organizations; A-21 - Colleges and Universities; 48 CFR 31.2 - For-Profit Organizations; 45 CFR 74 Appendix E – Hospitals.

3.19.2 Steven's Amendment – In accordance with the Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, Public Law 101-166, Section 511, "Steven's Amendment", the health plan shall not issue any statements, press releases, and other documents describing projects or programs funded in whole or in part with Federal funds unless the prior approval of the state agency is obtained and unless they clearly state the following as provided by the state agency:

a. The percentage of the total costs of the program or project which will be financed with Federal funds;
b. The dollar amount of Federal funds for the project or program; and
c. The percentage and dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

3.19.3 The health plan shall comply with 31 U.S.C. 1352 relating to limitations on use of appropriated funds to influence certain federal contracting and financial transactions. No funds under the contract shall be used to pay the salary or expenses of the health plan, or agent acting for the health plan, to engage in any activity designed to influence legislation or appropriations pending before the United States Congress or Missouri General Assembly. The health plan shall comply with all requirements of 31 U.S.C. 1352 which is incorporated herein as if fully set forth. The health plan shall submit to the state agency, when applicable, Disclosure of Lobbying Activities reporting forms.

a. The health plan shall guarantee and certify that no funds paid to the health plan by the state agency shall be used for the purpose of influencing or attempting to influence an officer or employee of any Federal or state agency, a member of the United States Congress, or State Legislature. The health plan shall disclose if any funds other than those paid to the health plan by the state agency have been used or will be used to influence the persons or entities indicated above and will assist the state agency in making such disclosures to CMS.

3.19.4 The health plan shall comply with the requirements of the Single Audit Act Amendments of 1996 (P.L. 104-156) and OMB Circular A-133, including subsequent amendments or revisions, as applicable or 2 CFR 215.26 as it relates to for-profit hospitals and commercial organizations. A copy of any audit report shall be sent to the state agency each contract year if applicable. The health plan shall return to the state agency any funds disallowed in an audit of the contract.

3.19.5 The health plan shall comply with the Pro-Children Act of 1994 (20 U.S.C. 6081), which prohibits smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

3.19.6 The health plan shall comply with 37 CFR part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations, as applicable.

3.19.7 The health plan shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251 et seq.).

3.19.8 If the health plan is a sub-recipient as defined in OMB Circular A-133, Section 210, the health plan shall comply with all applicable implementing regulations, and all other laws, regulations and policies authorizing or governing the use of any federal funds paid to the health plan through the contract.

3.19.9 The health plan shall comply with the public policy requirements as specified in the Department of Health and Human Services (HHS) Grants Policy Statement:
(http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf)

3.19.10 The health plan shall comply with Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104), as amended.

3.19.11 The health plan shall provide a drug free workplace in accordance with the Drug Free Workplace Act of 1988 and all applicable regulations. The health plan shall report any conviction of the health plan's personnel under a criminal drug statute for violations occurring on the health plan's premises or off the health plan's premises while conducting official business. A report of a conviction shall be made to the state agency within five (5) working days after the conviction.

3.19.12 Whistleblower Protections:

a. The health plan shall comply with the provisions of 41 U.S.C. 4712 that states an employee of a contractor, subcontractor, grantee, or subgrantee may not be discharged, demoted or otherwise discriminated against as a reprisal for "whistleblowing". In addition, whistleblower protections cannot be waived by any agreement, policy, form, or condition of employment.

b. The health plan's employees are encouraged to report fraud, waste, and abuse. The health plan shall inform their employees in writing they are subject to federal whistleblower rights and remedies. This notification must be in the predominant native language of the workforce.

c. The health plan shall include this requirement in any agreement made with a subcontractor or subgrantee.

3.20 Terminology - All references to the term "contractor" as used in the Terms and Conditions attached hereto shall mean "health plan".

4. PROPOSAL SUBMISSION INFORMATION

4.1 Submission of Proposals:

4.1.1 ELECTRONIC SUBMISSION OF PROPOSALS THROUGH THE ON-LINE BIDDING/VENDOR REGISTRATION SYSTEM WEB SITE IS NOT AVAILABLE FOR THIS RFP.

4.1.2 When submitting a proposal, the offeror should include nine (9) additional copies along with their original proposal. The front cover of the original proposal should be labeled "original" and the front cover of all copies should be labeled "copy". In case of a discrepancy between the original proposal and the copies, the original proposal shall govern.

a. In addition the offeror should provide a copy of their entire proposal, including all attachments, in Microsoft compatible format on a CD(s) or flash drive, with each copy of the proposal. The offeror should ensure all copies and all media are identical to the offeror's hardcopy original proposal. In case of a discrepancy, the original hardcopy proposal document shall govern.

b. Recycled Products - The State of Missouri recognizes the limited nature of our resources and the leadership role of government agencies in regard to the environment. Accordingly, the offeror is requested, but not required, to print the proposal double sided using recycled paper, if possible, and minimize or eliminate the use of non-recyclable materials such as plastic report covers, plastic dividers, vinyl sleeves, and binding. Lengthy proposals may be submitted using printer or other loose leaf paper in a notebook or binder.

4.1.3 Open Records - Pursuant to section 610.021, RSMo, the offeror's proposal shall be considered an open record after a contract is executed or all proposals are rejected. At that time, all proposals are scanned into the Division of Purchasing and Materials Management imaging system.

a. The scanned information will be available for viewing through the Internet from the Division of Purchasing and Materials Management Awarded Bid & Contract Document Search system. Therefore, the offeror is advised not to include any information in the proposal that the offeror does not want to be viewed by the public, including personal identifying information such as social security numbers.

b. In preparing a proposal, the offeror should be mindful of document preparation efforts for imaging purposes and storage capacity that will be required to image the proposals and should limit proposal content to items that provide substance, quality of content, and clarity of information.

4.1.4 To facilitate the evaluation process, the offeror is encouraged to organize their proposal into sections that correspond with the individual evaluation categories described herein. The offeror is cautioned that it is the offeror's sole responsibility to submit information related to the evaluation categories and that the State of Missouri is under no obligation to solicit such information if it is not included with the proposal. The offeror's failure to submit such information may cause an adverse impact on the evaluation of the proposal.

a. The proposal should be page numbered and should have an index and/or table of contents referencing the appropriate page number(s).

b. The signed page one from the original RFP and all signed amendments should be placed at the beginning of the proposal.

c. Each section should be titled with each individual evaluation category and all material related to that category should be included therein.

4.1.5 Questions Regarding the RFP – Except as may be otherwise stated herein, the offeror and the offeror's agents (including subcontractors, employees, consultants, or anyone else acting on their behalf) must direct all of their questions or comments regarding the RFP, the solicitation process, the evaluation, etc., to the buyer of record indicated on the first page of this RFP. Inappropriate contacts to other personnel are grounds for suspension and/or exclusion from specific procurements. Offerors and their agents who have questions regarding this matter should contact the buyer.

a. The buyer may be contacted via e-mail or phone as shown on the first page, or via facsimile to 573-526-9816.

b. Only those questions which necessitate a change to the RFP will be addressed via an amendment to the RFP. Written records of the questions and answers will not be maintained. Offerors are advised that any questions received less than ten calendar days prior to the RFP opening date may not be addressed.

c. The offeror may contact the Office of Equal Opportunity (OEO) regarding MBE/WBE certification or subcontracting with MBE/WBE companies.

4.2 Competitive Negotiation of Proposals - The offeror is advised that under the provisions of this Request for Proposal, the Division of Purchasing and Materials Management reserves the right to conduct negotiations of the proposals received or to award a contract without negotiations. If such negotiations are conducted, the following conditions shall apply**:**

4.2.1 Negotiations may be conducted in person, in writing, or by telephone.

4.2.2 Negotiations will only be conducted with potentially acceptable proposals. The Division of Purchasing and Materials Management reserves the right to limit negotiations to those proposals which received the highest rankings during the initial evaluation phase. All offerors involved in the negotiation process will be invited to submit a best and final offer.

4.2.3 Terms, conditions, prices, methodology, or other features of the offeror's proposal may be subject to negotiation and subsequent revision. As part of the negotiations, the offeror may be required to submit supporting financial, pricing and other data in order to allow a detailed evaluation of the feasibility, reasonableness, and acceptability of the proposal.

4.2.4 The mandatory requirements of the Request for Proposal shall <u>not</u> be negotiable and shall remain unchanged unless the Division of Purchasing and Materials Management determines that a change in such requirements is in the best interest of the State of Missouri.

4.3 Evaluation and Award Process:

4.3.1 After determining that a proposal satisfies the mandatory requirements stated in the Request for Proposal, the evaluator(s) shall use both objective analysis and subjective judgment in conducting a comparative assessment of the proposal in accordance with the evaluation criteria stated below. The contracts shall be awarded to the lowest and best proposals.

Evaluation Criteria Scoring Category	Maximum Points
MBE/WBE Participation	10 points
Organizational Experience	10 points
Method of Performance	20 points
Quality	60 points
Access to Care: • Primary Care ..... 15 points • Specialty Care ..... 15 points • Dental Services ..... 15 points • Behavioral Health ..... 15 points	60 points
Medicaid Reform and Transformation • Personal Responsibility ..... 10 points • State Provider Incentive Program ..... 10 points • Local Community Care Coordination Program ..... 10 points • Accountability and Transparency ..... 10 points	40 points
TOTAL	**200 points**

4.3.2 After an initial screening process, a question and answer conference or interview may be conducted with the offeror, if deemed necessary by the Division of Purchasing and Materials Management. In addition, the offeror may be asked to make an oral presentation of their proposal during the conference. Attendance cost at the conference shall be at the offeror's expense. All arrangements and scheduling shall be coordinated by the Division of Purchasing and Materials Management.

4.3.3 A single evaluation shall be conducted for the combined MO HealthNet Managed Care coverage area (Eastern, Central, and Western regions) and awards made accordingly.

4.3.4 The State of Missouri shall award no more than three (3) MO HealthNet Managed Care contracts for the combined MO HealthNet Managed Care coverage area (Eastern, Central, and Western regions).

4.4 Proposal Submission Information - The offeror should submit the information listed below:

4.4.1 The offeror should address each specific paragraph and subparagraph of the Scope of Work, Section 2, and General Contractual Requirements, Section 3, by identifying the paragraph number then providing a description of how, when, by whom, with what, to what degree, why, where, etc., the requirement will be satisfied and otherwise detailing the offeror's understanding of the requirements and ability and methodology to successfully perform. Additionally, within the offeror's response to the Scope of Work and General Contractual Requirements, the offeror should provide the information required/requested to be submitted with the offeror's proposal, as identified in Section 4, Proposal Submission Information.

The offeror should also identify each paragraph number within Section 4, Proposal Submission Information, and then provide the required/requested information. However, if the offeror has already provided the requested/required information within the offeror's response to the Scope of Work or the General Contractual Requirements, the offeror should identify the location within the offeror's proposal where the requested/required information is located.

Unless specifically requested, the offeror should not provide information or documentation more than once within the offeror's proposal. Further, the offeror is advised that if the

information/documentation is not submitted in the identified/referenced section or in the appropriate section, the State of Missouri is under no obligation to locate the information.

4.4.2 If the offeror is not a federally qualified HMO, the offeror should disclose the following information on certain types of business transactions the offeror has with a "party in interest" as defined in the Public Health Services Act.

a. Any sale, exchange, or lease of any property between the offeror's organization and a "party in interest."

b. Any lending of money or other extension of credit between the offeror's organization and a "party in interest."

c. Any furnishing for consideration of goods, services (including management services), or facilities between the offeror's organization and a "party in interest". This does not include salaries paid to employees for services provided in the normal course of their employment.

d. If the offeror has operated previously in the commercial or Medicare markets, the offeror should disclose the information listed below regarding business transactions for the previous year. The offeror should report all of the offeror's business transactions, not just the transactions relating to serving the MO HealthNet enrollment:

1) The name of the "party in interest" for each business transaction;

2) A description of each business transaction and the quantity or units involved;

3) The accrued dollar value of each business transaction during the fiscal year; and

4) Justification of the reasonableness of each business transaction.

e. For purposes of the above information, a "party in interest" shall be as defined herein.

BAFO 001 REVISED THE FOLLOWING PARAGRAPH:

4.4.3 The offeror should disclose the following in the format specified in "*Ownership or Controlling Interest Disclosure", "Transaction Disclosures",* and *"Provider and Subcontractor Disclosure"* located on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/).

a. Information Relating to Ownership and Control:

1) The name and address of any person (individual or corporation) with an ownership or control interest in the offeror's organization, or in any provider or subcontractor in which the offeror has an ownership of five percent (5%) or more; the date of birth (in the case of an individual); and the tax identification number (in the case of a corporation).

2) Whether a person(s) (individual or corporation) named is related as a spouse, parent, child, or sibling to another named person.

3) The name of any other disclosing entity (as defined in 42 CFR 455.101) in which the owner of the offeror's organization has an ownership or control interest.

4) The name, address, and date of birth of any managing employee of the offeror's organization.

b. Information on Criminal Convictions: The identity of any person who has an ownership or control interest in the offeror's organization, or is an agent or managing employee of the offeror's

organization and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Federal Title XX services program since the inception of those programs.

c. Information on Significant Business Transactions:

1) The ownership of any provider or subcontractor with whom the offeror's organization has had business transactions totaling more than $25,000.00 during the twelve (12) month period ending on the date of the disclosure.

2) Any significant business transactions (defined in 42 CFR 455.101 as those that, during any one fiscal year, exceed the lesser of $25,000.00 and five percent (5%) of the offeror's total operating expenses) between the offeror and any wholly owned supplier, or between the offeror and any provider or other subcontractor, during the five (5) year period ending on the date of the disclosure.

3) If the offeror is new to the MO HealthNet Managed Care Program, but the offeror has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period should be disclosed.

d. Definitions:

1) In general, the definitions listed in 42 CFR 455.101 shall govern disclosures under this subsection.

2) A "managing employee" is defined in 42 CFR 455.101 as a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

3) A "person with an ownership or control interest" shall mean a person or corporation that (1) has an ownership interest totaling five percent (5%) or more of the offeror's organization; (2) has an indirect ownership interest equal to five percent (5%) or more of the offeror's organization; (3) has a combination of direct and indirect ownership interests equal to five percent (5%) or more in the offeror's organization; (4) owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the offeror's organization or by its property or assets, if that interest is equal to or exceeds five percent (5%) of the total property and assets of the offeror's organization; (5) is an officer or director of the offeror's organization (if it is organized as a corporation); or (6) is a partner in the offeror's organization (if it is organized as a partnership).

- The percentage of direct ownership or control is calculated by multiplying the percent of interest which a person owns by the percent of the offeror's assets used to secure the obligation (e.g., if a person owns 10 percent (10%) of a note secured by sixty percent (60%) of the offeror's assets, the person owns six percent (6%) of the offeror).

- The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization (e.g., if a person owns ten percent (10%) of the stock in a corporation which owns eighty percent (80%) of the stock of the offeror's organization, the person owns eight percent (8%) of the offeror's organization).

e. Financial statements for all owners with five percent (5%) or more ownership interest should be submitted.

4.4.4 The offeror should provide certification that the offeror is not subject to exclusion by OIG pursuant to 42 CFR 1001.1001 (relating to OIG exclusion of entities owned or controlled by a sanctioned person) or 1001.1051 (relating to OIG exclusion of individuals with ownership or control interest in sanctioned entities).

a. Certification should be provided in the form of a notarized attestation letter signed by one of the following individuals:

1) The offeror's Chief Executive Officer;

2) The offeror's Chief Financial Officer; or

3) An individual who has delegated authority to sign for, and who reports directly to, the offeror's Chief Executive Officer or Chief Financial Officer.

4.4.5 The offeror should provide the following financial information pertaining to the offeror's organization (the legal entity that is submitting the proposal and that will be the party responsible for any contract awarded):

a. Audited financial statements and balance sheets for the previous three (3) years, or as many years up to three (3) years that the entity has been in operation. If the offeror has not been in operation for at least one (1) year, the offeror should submit unaudited financial statements and balance sheets. If the offeror is an existing HMO, a financial statement should be submitted on the form as prescribed by the National Association of Insurance Companies (NAIC) and should include an actuarial certification.

b. The following information (in table format) regarding the most recent audited financial statements:

1) Working capital;

2) Current ratio;

3) Quick ratio;

4) Net worth; and

5) Debt-to-worth ratio.

c. Financial plan for the offeror's current fiscal year.

d. Information about the offeror's financial forecasts for the original contract period and possible contract renewal periods. These forecasts should include at least income statements and enrollment forecasts.

e. A statement of whether there is any pending or recent (within the past five (5) years) litigation against the offeror. This should include, but not be limited to, litigation involving failure to provide timely, adequate, or quality physical or behavioral health services. The offeror does not need to report workers' compensation cases. If there is pending or recent litigation against the offeror, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include an opinion of counsel as to the degree of risk presented by any pending litigation and whether pending or recent litigation will impair the offeror's performance in a contract. The offeror should also include any Securities and Exchange Commission (SEC) filings discussing any pending or recent litigation. The offeror should also address the offeror's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

f. A statement of whether, within the past five (5) years, the offeror or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, the offeror should provide an explanation providing relevant details including the date in which the offeror emerged from bankruptcy or expects to emerge. If still in bankruptcy, the offeror should provide a summary of the court-approved reorganization plan. The offeror should also address the offeror's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

g. As applicable, provide (in table format) the offeror's current ratings, as well as ratings for each of the past three (3) years, from the following rating agencies. The offeror should also address the offeror's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

1) AM Best Company (financial strengths ratings);
2) TheStreet.com, Inc. (safety ratings);
3) Standard & Poor's (long-term insurer financial strength); and
4) Other rating agency.

h. Names and addresses of independent auditors.

i. Documentation of insurance coverage such as a list of the insurers used (including contact person and address) and the type and amounts of each policy held.

j. Proof of reinsurance.

4.4.6 Investigations – The offeror should provide the following information pertaining to any recent or pending investigations:

a. A statement of whether there have been any SEC investigations, civil or criminal, involving the offeror within the past five (5) years. If there have been any such investigations, provide an explanation with relevant details and outcome. Also provide a statement of whether there are any current or pending SEC investigations, civil or criminal, involving the offeror, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the offeror's performance in a contract. The offeror should address the offeror's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

b. A statement of whether the offeror is currently the subject, or has recently (within the past five (5) years) been the subject, of a criminal or civil investigation by a state or federal agency or state Medicaid agency other than SEC investigations. If the offeror is or has recently been the subject of such an investigation, the offeror should provide an explanation with relevant details and the outcome. The offeror should address the offeror's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

4.4.7 Debarment Certification –

a. Debarment Certification – The offeror certifies by signing the signature page of this original document and any amendment signature page(s) that the offeror is not presently debarred, suspended, proposed for debarment, declared ineligible, voluntarily excluded from participation, or otherwise excluded from or ineligible for participation under federal assistance programs. The offeror should complete and return the attached certification regarding debarment, etc., Exhibit G with the proposal. This document must be satisfactorily completed prior to award of the contract.

b. The offeror should identify and describe any debarment or suspension, regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any Federal or state regulatory entity or state Medicaid agency against the offeror's organization within the past five (5) years, which is not identified in subsection (a) above. In addition, identify and describe any letter of deficiency issued by, as well as any corrective actions requested or required by, any Federal or state regulatory entity or state Medicaid agency within the past five (5) years that relate to Medicaid or CHIP contracts. The offeror should include the offeror's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

c. The state agency will report to the Secretary of Health and Human Services any information it receives concerning an offeror that has been debarred.

4.4.8 The offeror should submit proof that the offeror has a Certificate of Authority from the Missouri Department of Insurance, Financial Institutions & Professional Registration to operate an HMO in each county specified herein.

a. If the offeror does not currently have a certificate for a certain county, the offeror should provide documentation that the offeror has or will submit an application to the Department of Insurance, Financial Institutions & Professional Registration for such certification.

b. If the offeror is new to the MO HealthNet Managed Care program, the offeror should begin the application process with the Department of Insurance, Financial Institutions, and Professional Registration no later than December 1, 2014 in order to ensure appropriate licensure by April 3, 2015. The offeror may contact Cindy Monroe, Admissions Specialist, with the DIFP via email at Cynthia.Monroe@insurance.mo.gov or via phone 573-751-4362 for assistance with the HMO licensure application process.

4.4.9 Health Care Service Subcontractors:

a. The offeror should list each health care service subcontractor to whom the offeror proposes to delegate contract requirements. Examples include, but are not limited to, behavioral health services, vision, or dental. The offeror should describe the services and activities that will be provided by such health service subcontractor.

b. Provide the names and mailing addresses of the health care service subcontractors and a description of the scope and portions of the work the health care service subcontractors will perform.

c. Describe how the offeror intends to monitor and evaluate the health care service subcontractors' performance.

d. Identify and describe any debarment or suspension, regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity or state Medicaid agency against the subcontractor within the past five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any Federal or state regulatory entity or state Medicaid agency within the past five (5) years that relate to subcontractor Medicaid or CHIP contracts. The offeror should address the subcontractors' parent organization, affiliates, and subsidiaries.

e. Specify whether there is any pending or recent (within the past five (5) years) litigation against a health care service subcontractor. This should include, but not be limited to, litigation involving failure to provide timely, adequate, or quality physical or behavioral health services. The offeror does not need to report workers' compensation cases. If there is pending or recent litigation against a health care service subcontractor, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Also the offeror should include any SEC filings discussing any pending or recent health care service

subcontractor litigation. The offeror should address the subcontractors' parent organization, affiliates, and subsidiaries.

f. Indicate if, within the past five (5) years, a health care service subcontractor or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, the offeror should provide an explanation providing relevant details including the date in which the health care service subcontractor emerged from bankruptcy or expects to emerge. If still in bankruptcy, the offeror should provide a summary of the health care service subcontractor's court-approved reorganization plan. The offeror should address the health care service subcontractors' parent organization, affiliates, and subsidiaries.

4.4.10 Personnel/Staffing - The offeror should submit information related to the qualifications of the proposed personnel concerning their experience in serving the Medicaid population or other state/federal health business, including education, training, and previous work assignments. In particular, the offeror should submit the following:

a. The number of employees, client base, and location of offices. The offeror's response should:

1) Include the activities and functions performed at each office location;

2) Demonstrate a physical presence in Missouri. Additionally, the offeror should demonstrate that the following personnel are located in and operate from Missouri: Health Plan Administrator, clerical and support staff, Medical Director, Dental Consultant, Chief Financial Officer, Quality Assessment and Improvement and Utilization Management Coordinator, Special Programs Coordinator, Case Management Supervisor and Staff, Behavioral Health Coordinator, Inpatient Certification Review Staff, Member Services Staff, Provider Services Staff, Compliance Officer, and Complaint, Grievance, and Appeal Coordinator; and

3) Address the offeror's parent organization, affiliates, and subsidiaries.

b. Resumes, job descriptions, and full time equivalent status for the offeror's Missouri-based Health Plan Administrator, Medical Director, Quality Assessment and Improvement and Utilization Management Coordinator, Special Programs Coordinator, Case Management Supervisor, Behavioral Health Coordinator, and Chief Financial Officer.

c. The offeror should identify which, if any, of the key positions, including the administrative personnel identified herein, are not filled, provide a rationale for why the positions are not filled, and provide timeframes for filling positions prior to readiness review activities.

d. Information for other personnel, including Dental Consultant, Complaint, Grievance, and Appeal Coordinator, Claims Administrator/MIS Director, and Compliance Officer.

e. Information on staffing levels, job descriptions, and qualifications for Prior Authorization Staff, Inpatient Certification Review Staff, Member Services Staff, and Provider Services Staff.

4.4.11 Claims Payment Processes - The offeror should submit the following information regarding the offeror's claims payment processes:

a. Information describing the offeror's claim adjudication processes. The offeror should provide a flow chart or written description that details the flow of claims from receipt until payment. Information should be provided documenting the offeror's audit trail of all claims that enter the system and any review processes that are in place.

b. The offeror should document the offeror's past and current performance with regard to the timely payment to in-network and out-of-network providers.

c. A description of the offeror's claims processing and management information system functions, including, but not limited to information about the offeror's liability management practices regarding its "Incurred But Not Reported Claims" and "Received But Unadjudicated Claims".

4.4.12 Member Services and Provider Services – The offeror should describe the hours of operation, holiday schedule, member and provider communication and education plans, and staff training plans for member services and provider services.

4.4.13 Member Grievance System – The offeror should describe the offeror's member grievance system being sure to address the grievance process, the appeal process, expedited resolution process, and process for ensuring that members receive proper notice of action.

4.4.14 Health Plan Under-Utilization Monitoring System - The offeror should describe how the offeror will define and monitor for the potential under-utilization of services by its members in order to assure that all covered services are being provided, as required. The offeror should outline how the offeror will investigate and correct the problem or problems which resulted in such underutilization of services if under-utilization is identified. In addition, the offeror should describe the offeror's ongoing review process of service denials and ongoing utilization monitoring system.

4.4.15 Release for Ethical Reasons - The offeror should state if reimbursement for, or provider coverage of, a counseling or referral service will be objected to based on moral or religious grounds.

4.4.16 Implementation Plan - The offeror should submit an implementation plan that identifies and elaborates on the critical actions the offeror will pursue to implement the programmatic responsibilities and performance requirements outlined herein. Submission of the implementation plan in no way affects the offeror's obligation to fulfill the readiness review requirements as described herein. The implementation plan should include the following minimum elements:

a. A list of the members of the implementation team, including each member's responsibilities and roles;

b. A staffing gap analysis and a plan with a timeline for hiring and training necessary personnel;

c. Process for communicating with new members, including methods, materials, and timeframes;

d. Process for communicating with providers regarding implementation and expectations, including methods, materials, and timeframes;

e. Process for identifying, tracking, and resolving issues during the first sixty (60) days of implementation including triaging priority issues;

f. A list and description of tasks critical to a successful implementation which have been completed as of the submission of the proposal;

g. A list and description of tasks critical to a successful implementation which the offeror expects to complete prior to the contract award date and the proposed dates of completion;

h. A list and description of tasks critical to a successful implementation which the offeror expects to complete prior to the contract effective date (July 1, 2015) and the proposed dates of completion; and

i. A list and description of significant tasks which will be completed after the contract effective date (July 1, 2015), along with the proposed date of completion and an explanation as to why these tasks will not be completed by the contract effective date.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

4.5 Organizational Experience: The offeror's organizational experience and the offeror's health care service subcontractors' organizational experiences will be considered subjectively in the evaluation process. Therefore, the offeror should submit the information specified below, to document the offeror and the proposed health care service subcontractors' experiences in past/current performances, especially those performances related to the requirements of this RFP. The offeror should utilize Exhibit A, or manner similar to the format provided on Exhibit A, to provide the requested information. Minimally, the offeror should document the experience of any behavioral health services, vision, and dental subcontractors. As applicable, the offeror's response should include the offeror's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business. The offeror should address any current/previous managed care experiences operating in the State of Missouri.

4.5.1 The offeror should identify all of the offeror's and the proposed health care service subcontractors' publicly-funded managed care contracts for Medicaid, CHIP, and/or other low-income individuals within the past five (5) years.

4.5.2 The offeror should also identify the offeror's and the proposed health care service subcontractors' five (5) largest (as measured by number of members) managed care contracts for populations other than Medicaid, CHIP, and/or other low-income individuals within the past five (5) years.

4.5.3 If the offeror or the proposed health care service subcontractors have not had any publicly-funded managed care contracts for Medicaid, CHIP, and/or other low-income individuals within the past five (5) years, the offeror should identify the offeror's and the proposed health care service subcontractors' ten (10) largest (as measured by number of members) managed care contracts for populations other than Medicaid, CHIP, and/or other low-income individuals within the past five (5) years.

4.5.4 For each prior contract identified, the offeror should provide a brief description of the scope of work (including whether the offeror/proposed subcontractor was responsible for the provision of physical health and/or behavioral health services), the duration of the contract, the contact name and telephone number, the number of members and the population types (e.g., TANF, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any.

a. References – For each such contract experience provided, the offeror should also provide reference contact information for a reference that can attest to the offeror's, subcontractor's, and benefit management organization's qualifications for fulfilling the requirements described.

4.5.5 The offeror should identify whether the offeror has had a contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/non-renewal and the parties involved, and provide the address and telephone number of the client. If the contract was terminated/non-renewed based on the offeror's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. The offeror's response should address the offeror's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

4.5.6 Within the past five (5) years, the offeror should identify whether a contracting party have found the offeror to be in breach of any of the offeror's physical or behavioral health services contracts:

a. Provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the offeror's control.

b. If a corrective action plan was imposed, describe the steps and timeframes in the corrective action plan and whether the corrective action plan was completed.

c. If a sanction was imposed, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage).

d. If the breach was the subject of an administrative proceeding or litigation, indicate the result of the proceeding/litigation.

The offeror's response should address the offeror's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

4.5.7 The offeror should identify any contracts in which the proposed health care service subcontractors are currently providing services for the offeror, provide a description of the services provided, and identify the state(s) where such services are being provided.

4.6 Method of Performance – The offeror's method of performance will be considered subjectively in the evaluation process. Therefore, the offeror should submit information, as specified below, to document that the offeror has the infrastructure, systems, and procedures to effectively deliver services and monitor member care. Accordingly, the offeror should address the following within the proposal.

4.6.1 Economic Impact to Missouri - The offeror should describe the economic advantages that will be realized as a result of the offeror performing the required services. The offeror should respond to the following:

a. Provide a description of the proposed services that will be performed and/or the proposed products that will be provided by Missourians and/or Missouri products.
b. Provide a description of the economic impact returned to the State of Missouri through tax revenue obligations.
c. Provide a description of the company's economic presence within the State of Missouri (e.g., type of facilities: sales offices; sales outlets; divisions; manufacturing; warehouse; other), including Missouri employee statistics.

4.6.2 Program Administration - The offeror should:

a. Describe the offeror's proposed process for monitoring service delivery including, at a minimum, the offeror's process for evaluating the adequacy, sufficiency, and appropriateness of provided services and monitoring patient outcomes.

b. Describe the offeror's proposed process for monitoring provider performance and the strategies proposed to be implemented, including but not limited to ongoing educational opportunities and corrective action plans to provide needed support.

c. Describe the strategies the offeror will implement to obtain member and provider feedback, to track and monitor identified issues, to identify systemic issues, and to make programmatic improvements based upon identified systemic issues.

d. Describe the offeror's proposed strategies for partnering with stakeholders (e.g. community-based service providers, local public health agencies, schools, state agencies, FQHCs, consumer groups, etc.).

e. Describe the offeror's proposed process for monitoring and tracking complaints, grievances, appeals, and denials.

f. Provide a listing, description, and conditions under which the offeror will offer additional health benefits to its members. Examples of such additional health benefits are non-emergency

transportation (NEMT) for those members who do not have NEMT as part of their benefit package; or sponsorship in youth programs such as Boy Scouts or YMCA. This is not an exhaustive list of such services but only provides examples of the types of services that may qualify as an additional health benefit. The offeror shall agree and understand that the award of contract does not constitute the state agency's approval or acceptance of the proposed additional health benefits.

4.6.3 Provider Services - The offeror should:

a. Describe the offeror's proposed process for evaluating the effectiveness of communication strategies (provider materials, newsletters, bulletins, website, education sessions, etc.) and maintaining and updating the accuracy of information. At a minimum, the offeror's response should include how the offeror will address specific program areas including EPSDT, lead, children with special health care needs, asthma, pre-natal care, dental services, behavioral health, reduction of inappropriate utilization of emergent services, and reduction of racial and ethnic health care disparities to improve health status.

b. Describe the offeror's proposed training and education activities for providers, including frequency and type, and if such training and education addresses specific program areas including EPSDT, lead, children with special health care needs, asthma, pre-natal care, dental services, behavioral health, reduction of inappropriate utilization of emergent services, and reduction of racial and ethnic health care disparities to improve health status.

c. Describe the activities proposed to monitor and track compliance with provider toll-free telephone line performance standards as described herein.

4.6.4 Member Services - The offeror should:

a. Describe how the offeror proposes to update members as information in the member handbook changes. The description should address, at a minimum, the offeror's strategies to ensure that members are informed of changes in a timely manner. The response should also include how the offeror will address specific program areas including EPSDT, lead, children with special health care needs, asthma, pre-natal care, dental services, behavioral health, reduction of inappropriate utilization of emergent services, and reduction of racial and ethnic health care disparities to improve health status.

b. Describe the offeror's proposed process for evaluating the effectiveness of communication strategies (member materials, newsletters, bulletins, website, education sessions, member handbook, etc.) and maintaining and updating the accuracy of information. At a minimum, the offeror's response should include how it will address specific program areas including EPSDT, lead, children with special health care needs, asthma, pre-natal care, dental services, behavioral health, reduction of inappropriate utilization of emergent services, and reduction of racial and ethnic health care disparities to improve health status.

c. Describe the offeror's proposed activities to monitor and track compliance with toll-free telephone line performance standards as described herein.

d. Describe how the offeror proposes to route calls among staff to ensure timely and accurate response to member inquiries, including procedures for referring the calls to supervisors and/or managers.

4.7 **Quality –** The offeror's ability to provide quality care and improve patient outcomes, as documented in current programs and the proposed programs, will be considered subjectively in the evaluation process. Therefore, the offeror should address the following within the proposal by utilizing Exhibit B, or providing the requested information in a manner similar to the format provided on Exhibit B.

4.7.1 The offeror should indicate if the offeror is NCQA-accredited. If so, the offeror should list the states in which the offeror is NCQA-accredited, and the accreditation status by product line. The offeror should also include a copy of the applicable NCQA report cards for the offeror. The offeror should include the offeror's parent organization, affiliates, and subsidiaries.

4.7.2 The offeror should indicate if the offeror ever had its accreditation status (e.g., NCQA, URAC, or AAAHC) in any state for any product line adjusted down, suspended, or revoked. If so, identify the state and product line and provide an explanation. The offeror should include the offeror's parent organization, affiliates, and subsidiaries.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

4.7.3 The offeror should provide the offeror's results for the following HEDIS measures for calendar years 2011, 2012, and 2013 for each of the offeror's Medicaid contracts (every state): Annual Dental Visits(ADV) - Total, Adolescent Well Care Visits (AWC), Use of Appropriate Medications for People with Asthma (ASM) - Total, Follow-up After Hospitalization for Mental Illness (FUH) - 7 Day Follow-up, Well Child Visits in the First 15 Months of Life (W15) – 6^+ Well Child Visits, Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care, and Ambulatory Care (AMB) – ED Visits. If the offeror does not have results for a particular HEDIS measure or year, provide the results that are available. If the offeror does not have the results for a Medicaid product line in a state where you have a Medicaid contract, provide the results for your Medicare (preferred) or commercial product line in that state (and indicate which product line the results apply to). If the offeror does not have results for every measure or year, provide the results available. If the offeror has measures for a Medicare or commercial product line in a particular state but you do not have such information for your Medicaid contract, provide that information. The offeror should explain any missing information (measure, year, or Medicaid contract). If the offeror has/had a MO HealthNet Managed Care contract, the offeror should provide their Missouri HEDIS measurements, separately for each region, during calendar years 2011, 2012, and 2013.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

4.7.4 The offeror should provide the offeror's proposed strategies for improving the MO HealthNet population health outcomes for the following HEDIS measures for the original contract period and the two renewal option periods: Annual Dental Visits (ADV) - Total, Adolescent Well Care Visits (AWC), Use of Appropriate Medications for People with Asthma (ASM) - Total, Follow-up After Hospitalization for Mental Illness (FUH) - 7 Day Follow-up, Well Child Visits in the First 15 Months of Life (W15) – 6^+ Well Child Visits, Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care, and Ambulatory Care (AMB) – ED Visits**.**

4.7.5 The offeror should address the Quality Assessment and Improvement Programs proposed to be implemented. The offeror should address how the proposed Quality Assessment and Improvement Programs will expand the quality improvement services beyond what the offeror is currently providing and the difference between the offeror's current programs and the proposed programs. The offeror should also indicate how the proposed Quality Assessment and Improvement Program will improve the health care status of the MO HealthNet population. The offeror should address the rationale for selecting the particular programs including the identification of particular health care problems and issues within the MO HealthNet population that each program will address and the underlying cause(s) of such problems and issues. Award of contract does not constitute approval or acceptance of the proposed Quality Assessment and Improvement Programs. The proposed Quality Assessment and Improvement programs may include, but is not necessarily, limited to the following:

a. New innovative programs and processes.

b. New contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts.

4.7.6 The offeror should provide an actionable plan to coordinate and manage care for identified superutilizers of avoidable emergency department and hospital services and medically complex individuals and how the offeror will track the process, evaluate outcomes, and implement evidence-based changes.

4.7.7 The offeror should provide a description of any focus studies performed, and quality improvement projects and any other improvements the offeror has implemented and their outcomes. Such outcomes should include cost savings realized, process efficiencies, and improvements to member health status. Such descriptions should address such activities since 2013. The offeror should address how issues and root causes were identified, and what was changed.

4.8 Access to Care – The offeror's access to Primary Care, Specialty Care, Dental Services, and Behavioral Health will be considered subjectively in the evaluation process. Therefore, the offeror should address the following information within the proposal.

4.8.1 Networks – The offeror should demonstrate adequate Primary Care, Specialty Care, Dental Services, and Behavioral Health provider networks to fulfill MO HealthNet requirements.

a. The offeror should submit documentation demonstrating that the offeror's Primary Care, Specialty Care, Dental Service, and Behavioral Health networks comply with travel distance standards as set forth by the Department of Insurance, Financial Institutions & Professional Registration in 20 CSR 400-7.095 regarding Provider Network Adequacy Standards. The offeror should also submit documentation for those Primary Care, Specialty Care, Dental Service, and Behavioral Health providers not addressed under 20 CSR 400-7.095, ensuring members will have access to Primary Care, Specialty Care, Dental Service, and Behavioral Health providers within thirty (30) miles unless the offeror can demonstrate that there is no licensed Primary Care, Specialty Care, Dental Service, and Behavioral Health provider in that area, in which case the offeror should ensure members have access to Primary Care, Specialty Care, Dental Service, and Behavioral Health providers within sixty (60) miles. For any demonstrated access that differs from these standards, the offeror should submit proof of approval of the differences by the Department of Insurance, Financial Institutions & Professional Registration.

b. The offeror should provide documentation verifying that the offeror's Primary Care, Specialty Care, Dental Service, and Behavioral Health network has adequate capacity. Such documentation should include, but it is not limited to, appointment availability, 24 hours/7 days a week access, sufficient experienced Primary Care, Specialty Care, Dental Service, and Behavioral Health providers to serve special needs populations, waiting times, open panels, and PCP to member ratios.

c. The offeror should describe how tertiary care providers for Primary Care, Specialty Care, Dental Service, and Behavioral Health services, including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists will be available twenty-four (24) hours per day in the regions. If the offeror does not have a full range of tertiary care providers, the offeror should describe how for Primary Care, Specialty Care, Dental, and Behavioral Health services will be provided including transfer protocols and arrangements with out of network facilities.

d. The offeror should complete and submit Exhibit C, Federally Qualified Health Centers, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Local Public Health Agencies, Family Planning and STD Providers, documenting each FQHC, RHC, CMHC, safety net hospitals (including acute care safety net hospitals as defined in 13 CSR 70-15.010 of the Code of State Regulations, as amended), LPHA, Family Planning, and STD Providers proposed to be included in the offeror's provider network.

4.8.2 Access Issues – The offeror should respond to each of the requests for information below (a. through e.) as it relates to each of the areas of evaluation: Primary Care, Specialty Care, Dental Services, and Behavioral Health Care.

a. The offeror should describe the methods proposed to address the unique needs of the Mo HealthNet members in each region and ensure that all populations in each region have access to Primary Care, Specialty Care, Dental, and Behavioral Health Care services. Accordingly, the offeror should **not** describe the following in its responses:

   1) Notices, mailings, information in the Member Handbook, etc., that are required under the Scope of Work specified herein;

   2) Distribution of literature, practice guidelines, etc. to providers; and

   3) Presence at local health fairs and other typical health-and-wellness events.

b. Given differences between urban and rural areas (e.g. population needs, access to care issues), the offeror should address how the offeror's orientation programs, education strategies, and interventions for providers and members in rural areas, as relates to Primary Care, Specialty Care, Dental Services, and Behavioral Health Care, will differ from those used in more urban areas of the State.

c. The offeror should describe how its approach to Primary Care, Specialty Care, Dental, and Behavioral Health Care service delivery will achieve optimal outcomes for the populations in each region. The offeror should describe the implications of the regional demographic data to their service delivery strategies (refer to Attachment 1, *MO HealthNet Managed Care and Related Eligibility Groups*, and located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/).

d. The offeror should describe the targeted initiatives proposed related to Primary Care, Specialty Care, Dental Services, and Behavioral Health Care to meet the requirements of the contract. The offeror should describe how the offeror will meet members' Primary Care, Specialty Care, Dental Services, and Behavioral Health Care needs in a coordinated and integrated manner as described per the contract requirements regarding provider network, access standards, quality assessment and improvement, case management, disease management, behavioral health and dental services.

e. The offeror should describe the approach/strategy for each of the requests for information below. If the described approach/strategy is one currently in use, the offeror should indicate in which program/state the approach/strategy is being used, the length of time the approach/strategy has been in effect, and the target population. If the offeror is currently operating in Missouri, the offeror should speak to their existing experience in Missouri as well as how they will modify and expand upon these strategies for future service delivery.

   1) How the offeror will ensure that children receive needed dental services. The offeror should identify and describe the approach(es) that the offeror plans to implement in relatively more urban counties and contrast these with interventions that the offeror plans to use in more rural areas of the State.

   2) The cost effective approaches the offeror will implement, aside from transportation, to ensure that members in relatively remote counties are able to access specialty care. The offeror should also describe the strategies the offeror will implement to outreach to specialty care providers. The offeror should describe how the offeror will facilitate and encourage the use of non-traditional service delivery approaches, such as regional clinics utilizing shared office space and equipment with local providers on a scheduled basis, by specialty care providers The offeror should describe how the offeror will monitor the effectiveness of such strategies.

   3) How the offeror will utilize telemedicine in rural areas of the State in regard to Primary Care, Specialty Care, Dental, and Behavioral Health Care services. At a minimum, the description

should include the specific strategies that will be used, purposes for which telemedicine will be used, targeted populations and conditions, and providers.

4) The specific measures the offeror will take to ensure that children and women identified as substance abusers are screened for depression and other co-occurring behavioral health conditions. The offeror should identify the case management activities and other strategies the offeror will use to link these members to appropriate resources, including behavioral health resources. The offeror should describe how the offeror will monitor effectiveness of care strategies. The offeror should describe how the efforts on behalf of members in rural areas will differ from those targeted to members in more urban areas.

5) How the offeror will ensure that Medicaid and CHIP children have access to child psychiatrists and psychologists for behavioral health services. The offeror should describe how the offeror will ensure appropriate case management and coordinated behavioral health services with the delivery of other services under the EPSDT benefit.

6) How the offeror will address the strategies the offeror will use to identify, reduce, and monitor inappropriate hospital readmissions in regard to Primary Care, Specialty Care, Dental, and Behavioral Health Care services. The offeror should describe to what extent these measures will differ according to populations, geographic locations, and health conditions.

7) Identify the tools the offeror will use to monitor emergency room utilization related to Primary Care, Specialty Care, Dental Services, and Behavioral Health Care and determine over utilization, and the measures the offeror proposes to combat/reduce emergency room overuse. The offeror should describe specific measures the offeror will take during the original contract period and each of the two renewal option periods.

8) How the offeror will utilize safety net providers (e.g. FQHCs, public health departments, CMHCs) to facilitate access to needed in regard to Primary Care, Specialty Care, Dental, and Behavioral Health Care services (including measures for identifying when safety net providers are needed and outreach to public providers). The offeror should also address how these strategies will differ between rural and urban areas of the State.

4.9 Medicaid Reform and Transformation – The offeror's proposed programs involving personal responsibility, promoting efficiency through state provider incentive programs, Local Community Care Coordination programs designed to engage members, providers, and health plans in transforming the state agency's service delivery system, and increasing accountability and transparecny will be considered subjectively in the evaluation process. Therefore, the offeror should address the following information within the proposal.

4.9.1 Personal Responsibility: The health plan should submit a draft of the offeror's member incentive programs. The offeror shall agree and understand that the award of contract does not constitute the state agency's approval or acceptance of the offeror's member incentive programs. For each member incentive program proposed, the offeror should provide the following information:

a. What the proposed member incentives are;
b. How the incentives are related to the health plan quality initiatives;
c. How the member incentives will be measured via quality activities;
d. The criteria for receiving the member incentive;
e. A definition of the population eligible for each member incentive;
f. How the health plan will promote the member incentive program;
g. The anticipated cost of the member incentive program; and
h. If applicable describe the extent to which the health plan is currently meeting this requirement.

4.9.2 State Provider Incentive Program – The offeror should provide a description of the offeror's state provider incentive programs and how such programs will be implemented and comply with the contractual requirements. The state provider incentive programs may include but not be limited to, the following provider types: primary care, behavioral health, CMHCs, FQHCs, RHCs, licensed clinical social workers (LCSWs), etc. If applicable, describe the extent to which the offeror is currently meeting this requirement.

4.9.3 Local Community Care Coordination Program(s) (LCCCP(s) through local healthcare providers - The offeror should:

a. Describe the extent to which the offeror is currently in arrangements with local providers (i.e., primary care, behavioral health, CMHCs, FQHCs, RHCs, licensed clinical social workers (LCSWs), etc.) to provide the type of services that would be potentially approvable by the state agency as a Local Community Care Coordination Program.

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

b. Describe how the offeror proposes to educate providers about the program requirements and provider expectations for the disease management, case management, LCCCP, and the state agency's health home programs.

c. Describe the strategies the offeror proposes to implement to: (1) work with providers to establish LCCCP(s); (2) monitor program outcomes and effectiveness of interventions; and (3) determine how to make improvements to the LCCCP(s).

AMENDMENT 1 REVISED THE FOLLOWING PARAGRAPH:

d. Describe how the offeror proposes to inform members about the, LCCCP(s),

e. Describe how the offeror will ensure that there is no duplication of services between the case management, disease management, LCCCP(s), and state agency health home programs.

f. If applicable, describe the extent to which the health plan is currently meeting this requirement.

4.9.4 Accountability and Transparency

a. Fraud and Abuse: The offeror should describe the internal controls, policies, and procedures to prevent, coordinate, detect, investigate, enforce, and report fraud, waste, and abuse. The offeror should also describe how employees, subcontractors, providers, and members will be educated about their responsibilities, the responsibilities of others, as well as how fraud, waste, and abuse is defined and how and in what instances to report it.

b. Transparency: The offeror should describe how they are going to meet the contractual requirements under the Operational Data Reporting section.

4.10 Evaluation of Offeror's Minority Business Enterprise (MBE)/ Women Business Enterprise (WBE) Participation:

4.10.1 In order for the Division of Purchasing and Materials Management (DPMM) to meet the provisions of Executive Order 05-30, the offeror should secure participation of certified MBEs and WBEs in providing the products/services required in this RFP. The targets of participation recommended by the State of Missouri are 10% MBE and 5% WBE of the total dollar value of the contract.

a. These targets can be met by a qualified MBE/WBE offeror themselves and/or through the use of qualified subcontractors, suppliers, joint ventures, or other arrangements that afford meaningful opportunities for MBE/WBE participation.

b. The services performed or the products provided by MBE/WBEs must provide a commercially useful function related to the delivery of the contractually-required service/product in a manner that will constitute an added value to the contract and shall be performed/provided exclusive to the performance of the contract. Therefore, if the services performed or the products provided by MBE/WBEs is utilized, to any extent, in the offeror's obligations outside of the contract, it shall not be considered a valid added value to the contract and shall not qualify as participation in accordance with this clause.

c. In order to be considered as meeting these targets, the MBE/WBEs must be "qualified" by the proposal opening date (date the proposal is due). (See below for a definition of a qualified MBE/WBE.)

4.10.2 The offeror's proposed participation of MBE/WBE firms in meeting the targets of the RFP will be considered in the evaluation process as specified below:

a. <u>If Participation Meets Target:</u> Offerors proposing MBE and WBE participation percentages that meet the State of Missouri's target participation percentage of 10% for MBE and 5% for WBE shall be assigned the maximum stated MBE/WBE Participation evaluation points.

b. <u>If Participation Exceeds Target:</u> Offerors proposing MBE and WBE participation percentages that exceed the State of Missouri's target participation shall be assigned the same MBE/WBE Participation evaluation points as those meeting the State of Missouri's target participation percentages stated above.

c. <u>If Participation Below Target:</u> Offerors proposing MBE and WBE participation percentages that are lower than the State of Missouri's target participation percentages of 10% for MBE and 5% for WBE shall be assigned a proportionately lower number of the MBE/WBE Participation evaluation points than the maximum MBE/WBE Participation evaluation points.

d. <u>If No Participation:</u> Offerors failing to propose any commercially useful MBE/WBE participation shall be assigned a score of 0 in this evaluation category.

4.10.3 MBE/WBE Participation evaluation points shall be assigned using the following formula:

$$\frac{\text{Offeror's Proposed MBE \% } \leq 10\% + \text{WBE \% } \leq 5\%}{\text{State's Target MBE \% (10) + WBE \% (5)}} \times \begin{array}{c}\text{Maximum}\\ \text{MBE/WBE}\\ \text{Participation}\\ \text{Evaluation points}\\ (10)\end{array} = \begin{array}{c}\text{Assigned}\\ \text{MBE/WBE}\\ \text{Participation}\\ \text{points}\end{array}$$

4.10.4 If the offeror is proposing MBE/WBE participation, in order to receive evaluation consideration for MBE/WBE participation, the offeror <u>must</u> provide the following information with the proposal.

a. Participation Commitment - If the offeror is proposing MBE/WBE participation, the offeror must complete Exhibit D, Participation Commitment, by listing each proposed MBE and WBE, the committed percentage of participation for each MBE and WBE, and the commercially useful products/services to be provided by the listed MBE and WBE. If the offeror submitting the proposal is a qualified MBE and/or WBE, the offeror must include the offeror in the appropriate table on the Participation Commitment Form.

b. Documentation of Intent to Participate – The offeror must either provide a properly completed Exhibit E, Documentation of Intent to Participate Form, signed and dated no earlier than the RFP issuance date by each MBE and WBE proposed or must provide a letter of intent signed and dated no earlier than the RFP issuance date by each MBE and WBE proposed which: (1) must describe the products/services the MBE/WBE will provide and (2) should include evidence that the MBE/WBE is qualified, as defined herein (i.e., the MBE/WBE Certification Number or a copy of MBE/WBE

certificate issued by the Missouri OEO). If the offeror submitting the proposal is a qualified MBE and/or WBE, the offeror is not required to complete Exhibit E, Documentation of Intent to Participate Form or provide a recently dated letter of intent.

4.10.5 Commitment – If the offeror's proposal is awarded, the percentage level of MBE/WBE participation committed to by the offeror on Exhibit D, Participation Commitment, shall be interpreted as a contractual requirement.

4.10.6 Definition -- Qualified MBE/WBE:

a. In order to be considered a qualified MBE or WBE for purposes of this RFP, the MBE/WBE must be certified by the State of Missouri, Office of Administration, Office of Equal Opportunity (OEO) by the proposal opening date.

b. MBE or WBE means a business that is a sole proprietorship, partnership, joint venture, or corporation in which at least fifty-one percent (51%) of the ownership interest is held by minorities or women and the management and daily business operations of which are controlled by one or more minorities or women who own it.

c. Minority is defined as belonging to one of the following racial minority groups: African Americans, Native Americans, Hispanic Americans, Asian Americans, American Indians, Eskimos, Aleuts, and other groups that may be recognized by the Office of Advocacy, United States Small Business Administration, Washington, D.C.

4.10.7 Resources - A listing of several resources that are available to assist offerors in their efforts to identify and secure the participation of qualified MBEs and WBEs is available at the website shown below or by contacting the Office of Equal Opportunity (OEO) at:

Office of Administration, Office of Equal Opportunity (OEO)
Harry S Truman Bldg., Room 630, P.O. Box 809, Jefferson City, MO 65102-0809
Phone: (877) 259-2963 or (573) 751-8130
Fax: (573) 522-8078
Web site: http://oeo.mo.gov

4.11 Miscellaneous Submittal Information:

4.11.1 Organizations for the Blind and Sheltered Workshop Preference - Pursuant to section 34.165, RSMo, and 1 CSR 40-1.050, a ten (10) bonus point preference shall be granted to offerors including products and/or services manufactured, produced or assembled by a qualified nonprofit organization for the blind established pursuant to 41 U.S.C. sections 46 to 48c or a sheltered workshop holding a certificate of approval from the Department of Elementary and Secondary Education pursuant to section 178.920, RSMo.

a. In order to qualify for the ten bonus points, the following conditions must be met and the following evidence must be provided:

1) The offeror must either be an organization for the blind or sheltered workshop or must be proposing to utilize an organization for the blind/sheltered workshop as a subcontractor and/or supplier in an amount that must equal the greater of $5,000 or 2% of the total dollar value of the contract for purchases not exceeding $10 million.

2) The services performed or the products provided by an organization for the blind or sheltered workshop must provide a commercially useful function related to the delivery of the contractually-required service/product in a manner that will constitute an added value to the contract and shall be performed/provided exclusive to the performance of the contract.

Therefore, if the services performed or the products provided by the organization for the blind or sheltered workshop is utilized, to any extent, in the offeror's obligations outside of the contract, it shall not be considered a valid added value to the contract and shall not qualify as participation in accordance with this clause.

3) If the offeror is proposing participation by an organization for the blind or sheltered workshop, in order to receive evaluation consideration for participation by the organization for the blind or sheltered workshop, the offeror must provide the following information with the proposal:

- Participation Commitment - The offeror must complete Exhibit D, Participation Commitment, by identifying the organization for the blind or sheltered workshop and the commercially useful products/services to be provided by the listed organization for the blind or sheltered workshop. If the offeror submitting the proposal is an organization for the blind or sheltered workshop, the offeror must be listed in the appropriate table on the Participation Commitment Form.

- Documentation of Intent to Participate – The offeror must either provide a properly completed Exhibit E, Documentation of Intent to Participate Form, signed and dated no earlier than the RFP issuance date by the organization for the blind or sheltered workshop proposed or must provide a recently dated letter of intent signed and dated no earlier than the RFP issuance date by the organization for the blind or sheltered workshop which: (1) must describe the products/services the organization for the blind/sheltered workshop will provide and (2) should include evidence of the organization for the blind/sheltered workshop qualifications (e.g. copy of certificate or Certificate Number for Missouri Sheltered Workshop).

  NOTE: If the offeror submitting the proposal is an organization for the blind or sheltered workshop, the offeror is not required to complete Exhibit E, Documentation of Intent to Participate Form or provide a recently dated letter of intent.

b. A list of Missouri sheltered workshops can be found at the following Internet address:
http://dese.mo.gov/special-education/sheltered-workshops/directories

c. The websites for the Missouri Lighthouse for the Blind and the Alphapointe Association for the Blind can be found at the following Internet addresses:
http://www.lhbindustries.com
http://www.alphapointe.org

d. Commitment – If the offeror's proposal is awarded, the organization for the blind or sheltered workshop participation committed to by the offeror on Exhibit D, Participation Commitment, shall be interpreted as a contractual requirement.

4.11.2 Service-Disabled Veteran Business Enterprises (SDVEs) – Pursuant to section 34.074, RSMo, and 1 CSR 40-1.050, the Division of Purchasing and Materials Management (DPMM) has a goal of awarding three (3) percent of all contracts for the performance of any job or service to qualified service-disabled veteran business enterprises (SDVEs). A three (3) point bonus preference shall be granted to offerors including products and/or services manufactured, produced or assembled by a qualified SDVE.

a. In order to qualify for the three bonus points, the following conditions must be met and the following evidence must be provided:

1) The offeror must either be an SDVE or must be proposing to utilize an SDVE as a subcontractor and/or supplier that provides at least three percent (3%) of the total contract value.

2) The services performed or the products provided by the SDVE must provide a commercially useful function related to the delivery of the contractually-required service/product in a manner that will constitute an added value to the contract and shall be performed/provided exclusive to the performance of the contract. Therefore, if the services performed or the products provided by the SDVE are utilized, to any extent, in the offeror's obligations outside of the contract, it shall not be considered a valid added value to the contract and shall not qualify as participation in accordance with this clause.

3) In order to receive evaluation consideration for participation by an SDVE, the offeror must provide the following information with the proposal:

- Participation Commitment - The offeror must complete Exhibit D, Participation Commitment, by identifying each proposed SDVE, the committed percentage of participation for each SDVE, and the commercially useful products/services to be provided by the listed SDVE. If the offeror submitting the proposal is a qualified SDVE, the offeror must be listed in the appropriate table on the Participation Commitment Form.

- Documentation of Intent to Participate – The offeror must either provide a properly completed Exhibit E, Documentation of Intent to Participate Form, signed and dated no earlier than the RFP issuance date by the SDVE or a recently dated letter of intent signed and dated no earlier than the RFP issuance date by the SDVE which: (1) must describe the products/services the SDVE will provide and (2) must include the SDV Documents described below as evidence that the SDVE is qualified, as defined herein.

- Service-Disabled Veteran (SDV) Documents - If a participating organization is an SDVE, unless previously submitted within the past five (5) years to the DPMM, the offeror **must** provide the following Service-Disabled Veteran (SDV) documents:

  ✓ a copy of the SDV's award letter from the Department of Veterans Affairs or a copy of the SDV's discharge paper (DD Form 214, Certificate of Release or Discharge from Active Duty); and
  ✓ a copy of the SDV's documentation certifying disability by the appropriate federal agency responsible for the administration of veterans' affairs.

  NOTE:

  a) If the offeror submitting the proposal is a qualified SDVE, the offeror must include the SDV Documents as evidence that the offeror qualifies as an SDVE. However, the offeror is not required to complete Exhibit E, Documentation of Intent to Participate Form or provide a recently dated letter of intent.

  b) If the SDVE and SDV are listed on the following Internet address, the offeror is not required to provide the SDV Documents listed above.
  http://content.oa.mo.gov/sites/default/files/sdvelisting.pdf

b. Commitment – If awarded a contract, the SDVE participation committed to by the offeror on Exhibit D, Participation Commitment, shall be interpreted as a contractual requirement.

c. Definition - Qualified SDVE:

1) SDVE is doing business as a Missouri firm, corporation, or individual or maintaining a Missouri office or place of business, not including an office of a registered agent;

2) SDVE has not less than fifty-one percent (51%) of the business owned by one (1) or more service-disabled veterans (SDVs) or, in the case of any publicly-owned business, not less than fifty-one percent (51%) of the stock of which is owned by one (1) or more SDVs;

3) SDVE has the management and daily business operations controlled by one (1) or more SDVs;

4) SDVE has a copy of the SDV's award letter from the Department of Veterans Affairs or a copy of the SDV's discharge paper (DD Form 214, Certificate of Release or Discharge from Active Duty), and a copy of the SDV's documentation certifying disability by the appropriate federal agency responsible for the administration of veterans' affairs; and

5) SDVE possesses the power to make day-to-day as well as major decisions on matters of management, policy, and operation.

4.11.3 Affidavit of Work Authorization and Documentation - Pursuant to section 285.530, RSMo, if the offeror meets the section 285.525, RSMo, definition of a "business entity" (http://www.moga.mo.gov/statutes/C200-299/2850000525.HTM), the offeror must affirm the offeror's enrollment and participation in the E-Verify federal work authorization program with respect to the employees hired after enrollment in the program who are proposed to work in connection with the services requested herein. The offeror should complete applicable portions of Exhibit F, Business Entity Certification, Enrollment Documentation, and Affidavit of Work Authorization. The applicable portions of Exhibit F must be submitted prior to an award of a contract.

4.11.4 The offeror should complete and submit Exhibit H, Miscellaneous Information.

4.11.5 Proposal Security Deposit Required: The offeror must furnish a proposal security deposit in the form of an original bond (copies or facsimiles shall not be acceptable), check, cash, bank draft, or irrevocable letter of credit to the Office of Administration, Division of Purchasing and Materials Management by the proposal opening date and time. The Request for Proposal number must be specified on the proposal security deposit.

a. The proposal security deposit must be made payable to the State of Missouri in the amount of $500,000.00.

b. Any proposal security deposit submitted shall remain in force until such time as the health plan submits a performance security deposit pursuant to the contract requirements specified elsewhere herein. Failure to submit a performance security deposit in the time specified or failure to accept award of the contract shall be deemed sufficient cause to forfeit the proposal security deposit.

c. If the proposal security deposit is submitted in the form of cash or a check, it will be deposited. However, the Division of Purchasing and Materials Management shall issue a check in the same amount as the offeror's proposal security deposit to the offeror either once the performance security deposit is received if the offeror is awarded the contract, or at the time of award of the contract if the offeror is not awarded a contract.

d. The proposal security deposit must be submitted in the name of the offeror submitting the proposal, rather than the offeror's parent company, owner, etc..

4.11.6 Business Compliance - The offeror must be in compliance with the laws regarding conducting business in the State of Missouri. The offeror certifies by signing the signature page of this original document and any amendment signature page(s) that the offeror and any proposed subcontractors either are presently in compliance with such laws or shall be in compliance with such laws prior to any resulting contract award. The offeror shall provide documentation of compliance upon request by the Division of Purchasing and Materials Management. The compliance to conduct business in the state shall include, but not necessarily be limited to:

a. Registration of business name (if applicable)
b. Certificate of authority to transact business/certificate of good standing (if applicable)
c. Taxes (e.g., city/county/state/federal)
d. State and local certifications (e.g., professions/occupations/activities)
e. Licenses and permits (e.g., city/county license, sales permits)
f. Insurance (e.g., worker's compensation/unemployment compensation)

5. PRICING PAGE

5.1 Pricing Page: The following charts document the actuarially sound firm, fixed rates for providing all required services for all specified counties within a region pursuant to the requirements of this Request for Proposal. For the period represented on the Pricing Pages, the offeror shall indicate with an "x" in Column 2 of the Pricing Page its acceptance of the offered firm, fixed rate for each regional combination of Category of Aid and Age grouping, Supplemental Payment for each Delivery Event, and Supplemental Payment for each Neonatal Intensive Care Unit (NICU) Birth. All proposals shall cover the Western, Central and Eastern regions. All costs associated with providing the required services are included in the firm, fixed rates.

The offeror must complete Column 2 on Pricing Page 5.2 for the Western region, Column 2 on Pricing Page 5.3 for the Central region, and Column 2 on Pricing Page 5.4 for the Eastern region.

5.1.1 Requirements promulgated by the federal government stipulate that the State of Missouri can only contract for services at rates that are actuarially sound. For each period represented on the Pricing Pages , Column 1 lists the State's Base Capitation Rate (prior to risk adjustment) for each Category of Aid, each Delivery Event, and each NICU Birth. Each rate listed in Column 1 is actuarially sound, compliant with federal regulations, and is the firm, fixed rate that the State will allow.

5.1.2 To assist the offeror in review of the firm, fixed rates, the offeror should use the information provided in the Attachment 2, *Data Book*. However, the offeror is advised that this information should not be used as the only source of information in making pricing decisions. The offeror is solely responsible for research, preparation, and documentation of the offeror's proposal including the acceptance of the rates quoted on the Pricing Page.

a. Any health plan considering contracting with the State should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rate ranges before deciding whether to contract with the State. In addition to completing the Pricing Pages as indicated above, the health plan shall provide actuarial certification.

b. Requirements promulgated by the federal government stipulate that the State of Missouri can only contract for services at rates that are within actuarially sound rate ranges. The actuarial soundness of rates differing from those of the State shall be reviewed by the State of Missouri during the formal evaluation of the proposals.

c. The offeror must submit information which establishes and supports the actuarial soundness of the proposed rates and a certification of said soundness from an Associate of the Society of Actuaries (ASA), a Fellow of Society of Actuaries (FSA), or a Member of the American Academy of Actuaries (MAAA).

d. The offeror shall understand that the decision of the State of Missouri regarding whether or not a rate is within actuarially sound rate ranges shall be final and without recourse.

5.1.3 The firm, fixed prices on the Pricing Pages reflect the following.

a. The actuarially sound firm, fixed rates provided do <u>not</u> include:

1) Estimates for services which are not the offeror's responsibility.

2) Cost of marketing as an administrative expense associated with the start-up fees and costs to support expansion into Missouri Medicaid regions.

b. The actuarially sound firm, fixed rates provided are net of Third Party Liability recoveries.

c. The actuarially sound firm, fixed rates calculate medical expenses for each combination of Category of Aid and Age grouping and make adjustments for administrative, profit, and contingency and risk charges.

d. The actuarially sound firm, fixed rates reflect the average risk of the region.

e. The offeror must accept the actuarially sound firm, fixed PMPM Base Capitation Rate for each combination of Category of Aid and Age grouping; firm, fixed Supplemental Payment for each Delivery Event; and firm, fixed Supplemental Payment for each NICU Birth. The State shall not consider awarding a contract to an offeror with any quoted rate which deviates from the State's firm, fixed rate listed in Column 1

PRICING PAGES

Pricing Pages 5.1, 5.2, and 5.3 are a separate link that must be downloaded separately from the Division of Purchasing and Materials Management's Internet web site at: https://www.moolb.mo.gov.

AMENDMENT 1 REVISED EXHIBIT A:

EXHIBIT A

ORGANIZATIONAL EXPERIENCE

Publicly Funded Managed Care Contracts: The offeror should identify the offeror's and the proposed health care service subcontractors' publicly-funded managed care contracts for Medicaid, CHIP, and/or other low-income individuals within the past five (5) years.

Offeror's Publicly-Fund Managed Care Contracts:	Number of Members	Population Served (e.g. Medicaid, CHIP, and/or other low-income individuals)

Subcontractor's Publicly-Fund Managed Care Contracts (Identify Subcontractor):	Number of Members	Population Served (e.g. Medicaid, CHIP, and/or other low-income individuals)

Managed Care Contracts for Populations Other than Medicaid, CHIP, and/or Other Low-Income Individuals -The offeror should identify the offeror's and the proposed health care service subcontractors' five (5) largest (as measured by number of members) managed care contracts for populations other than Medicaid, CHIP, and/or other low-income individuals within the past five (5) years.

Offeror's Publicly-Fund Managed Care Contracts:	Number of Members	Population Served other than. Medicaid, CHIP, and/or other low-income individuals

Subcontractor's Publicly-Fund Managed Care Contracts (Identify Subcontractor):	Number of Members	Population Served other than. Medicaid, CHIP, and/or other low-income individuals

EXHIBIT A CONTINUED

ORGANIZATIONAL EXPERIENCE

AMENDMENT 1 REVISED THE FOLLOWING ITEM OF EXHIBIT A:

Non-Publicly Funded Managed Care Contracts for Populations Other Than Medicaid, CHIP, and/or Other Low-Income Individuals - If the offeror or the proposed health care service subcontractors have not had any publicly-funded managed care contracts for Medicaid, CHIP, and/or other low-income individuals, the offeror should identify the offeror's and the proposed health care service subcontractors' ten (10) largest (as measured by number of members) managed care contracts for populations other than Medicaid, CHIP, and/or other low-income individuals within the past five (5) years.

Offeror's Non-Publicly Funded Managed Care Contracts:	Number of Members	Population Served (e.g. Medicaid, CHIP, and/or other low-income individuals)

Subcontractor's Non-Publicly Funded Managed Care Contracts (Identify Subcontractor):	Number of Members	Population Served (e.g. Medicaid, CHIP, and/or other low-income individuals)

EXHIBIT A CONTINUED

ORGANIZATIONAL EXPERIENCE

The offeror should copy and complete this form documenting the offeror and subcontractor's current/prior experience considered relevant to the services required herein. In addition, the offeror is advised that if the contact person listed for verification of services is unable to be reached during the evaluation, the listed experience may not be considered.

Offeror Name or Subcontractor Name: _____
(if reference is for a Subcontractor):

Reference Information (Current/Prior Services Performed For:)

Name, Title, Address, and Contact Information (phone number and email address) for Reference Company/Client:					
Title/Name of Service/Contract					
Dates of Service/Contract:					
If service/contract has terminated, specify reason:					
Number of Members and Population (e.g. Medicaid, CHIP, Other Low Inlcude Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year:	Year:	Year:	Year:	Year:
	Population: No. of Members:	Population: No. of Members:	Population: No. of Members:	Population: No. of Members:	Population: No. of Members:
Annual Contract Payment:	Year:	Year:	Year:	Year:	Year:
Description of Services Performed, including whether the offeror was responsible for the provision of physical health and/or behavioral health services:					
Capitated Payment:	___ Yes ___ No If No, describe:				
Role of any Subcontractors:					

EXHIBIT A CONTINUED

ORGANIZATIONAL EXPERIENCE

Contracts Terminated/Non-Renewed: The offeror should identify whether the offeror has had a contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/non-renewal and the parties involved, and provide the address and telephone number of the client. If the contract was terminated/non-renewed based on the offeror's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. The offeror's response should address the offeror's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

Offeror's Terminated/Non-Renewed Contracts:	Contracting Entity, including Address and Telephone Number	Reason, Including any Corrective Action Taken to Prevent Future Occurrence of the Problem

AMENDMENT 1 REVISED THE FOLLOWING ITEM OF EXHIBIT A:

Contracts Breached: The offeror should identify whether a contracting party has found the offeror to be in breach of any of the offeror's physical or behavioral health services contracts within the past five (5) years. If so, (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the offeror's control, (2) if a corrective action plan was imposed, describe the steps and timeframes in the corrective action plan and whether the corrective action plan was completed, (3) if a sanction was imposed, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage), and (4) if the breach was the subject of an administrative proceeding or litigation, indicate the result of the proceeding/litigation. The offeror's response should address the offeror's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

Contract Breached	Description of the Events Concerning the Breach, including Whether the Breach was Due to Factors Beyond the Offeror's Control	Describe the Steps and Timeframes of the Corrective Action Plan, if any, and Whether the Corrective Action Plan was Completed	Describe any Sanction, Including the Amount of any Monetary Sanction, Imposed	Indicate the Result of Proceeding or Litigation, if any

EXHIBIT A CONTINUED

ORGANIZATIONAL EXPERIENCE

Current Subcontract Relationships: The offeror should identify any contracts in which the proposed health care service subcontractors are currently providing services for the offeror, provide a description of the services provided and the state(s) where such services are being provided

Health Service Subcontractor	Contract	Description of Service Provided	State Where Services are Being Provided

AMENDMENT 1 REVISED EXHIBIT B:

EXHIBIT B

QUALITY

The offeror should provide the following information addressing quality care and improve patient outcomes. The offeror should add additional lines to each table or make copies of this form as necessary.

NCQA Accreditation: If the offeror is NCQA- accredited, the offeror should list the states in which the offeror should provide the following information. The offeror should also include a copy of the applicable NCQA report cards for the offeror. The offeror should include the offeror's parent organization, affiliates, and subsidiaries.

Health Plan	States in which the Offeror is NCQA Accredited:	Accreditation Status, and Date of Accreditation	Product Line	Level of Accreditation (e.g. Commendable, Excellent), including dates for such level of accreditation

If the offeror has ever had its accreditation status (e.g., NCQA, URAC, or AAAHC) in any state for any product line adjusted down, suspended, or revoked, identify the state and product line and provide an explanation. The offeror should include the offeror's parent organization, affiliates, and subsidiaries.

Health Plan	Type of Accreditation (e.g.NCQA, URAC, or AAAHC)	Original and Adjusted Accreditation Status, including dates	State(s) in which the Offeror's NCQA Accreditation was Adjusted Down, Suspended, or Revoked:	Product Line	Explanation

EXHIBIT B CONTINUED

QUALITY

AMENDMENT 1 REVISED THE FOLLOWING ITEM OF EXHIBIT B:

HEDIS Measures: For each of the offeror's Medicaid contracts, the offeror should provide the offeror's results for the following HEDIS measures for years 2011, 2012, and 2013. If the results for a particular HEDIS measure or year are not available, provide the results that are available. If the offeror does not have the results for a Medicaid product line in a state where you have a Medicaid contract, provide the results for your Medicare (preferred) or commercial product line in that state (and indicate which product line the results apply to). If the offeror does not have results for every measure or year, provide the results that are available. If the offeror has measures for a Medicare or commercial product line in a particular state but you do not have such information for your Medicaid contract, provide that information. The offeror should explain any missing information (measure, year, or Medicaid contract). If the offeror has/had a MO HealthNet Managed Care contract, the offeror should provide their Missouri HEDIS measurements, separately for each region, during 2011, 2012, and 2013. The offeror should copy and complete this form for each contract.

Health Plan and State:

	Annual Dental Visits (ADV) - Total	Adolescent Well Care Visits (AWC)	Use of Appropriate Medications for People with Asthma (ASM) - Total	Follow-up After Hospitalization for Mental Illness (FUH) - 7 day Follow-UP	Well Child Visits in the First 15 Months of Life (W15) – 6^+ Well Child Visits	Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	Ambulatory Care (AMB) – ED Visits
2011							
2012							
2013							

EXHIBIT B CONTINUED

QUALITY

AMENDMENT 1 REVISED THE FOLLOWING ITEM OF EXHIBIT B:

Health Outcome Improvement Strategies: The offeror's strategies for improving the MO HealthNet population health outcomes for the following HEDIS measures.

	Original Contract Period	First Renewal Period	Second Renewal Period
Annual Dental Visits (ADV)- Total			
Adolescent Well Care Visits (AWC)			
Use of Appropriate Medications for People with Asthma (ASM)- Total			
Follow-up After Hospitalization for Mental Illness (FUH)- 7 day Follow-up			
Well Child Visits in the First 15 Months of Life (W15)-6^+ Well Child Visits			
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care			
Ambulatory Care (AMB)- ED Visits			

EXHIBIT B CONTINUED

QUALITY

Quality Assessment and Improvement Programs: The offeror should address the Quality Assessment and Improvement Programs proposed to be implemented. The offeror should address how the proposed Quality Assessment and Improvement Programs will expand the quality improvement services beyond what the offeror is currently providing and the difference between the offeror's current programs and the proposed programs. The offeror should also indicate how the proposed Quality Assessment and Improvement Program will improve the health care status of the MO HealthNet population. The offeror should address the rationale for selecting the particular programs including the identification of particular health care problems and issues within the MO HealthNet population that each program will address and the underlying cause(s) of such problems and issues. Award of contract does not constitute approval or acceptance of the proposed Quality Assessment and Improvement Programs.

Quality Assessment and Improvement Programs	How the proposed programs will expand the quality improvement services beyond what the offeror is currently providing and the difference between the offeror's current programs and the proposed programs	How the proposed program will improve the health care status of the MO HealthNet population	Rationale for selecting the particular program including the identification of particular health care problems and issues within the MO HealthNet population that the program will address and the underlying cause(s) of such problems and issues

EXHIBIT B CONTINUED

QUALITY

Action Plan: The offeror should provide an actionable plan to coordinate and manage care for identified superutilizers of avoidable emergency department and hospital services and medically complex individuals and how the offeror will track the process, evaluate outcomes, and implement evidence-based changes

Description of Plan to Coordinate and Manage Care for Identified Superutilizers of Avoidable Emergency Department and Hospital Services and Medically Complex Individuals:	
Method Proposed to Track the Process:	
Method Proposed to Evaluate Outcomes:	
Method Proposed to Implement Evidence-Based Changes:	

EXHIBIT B CONTINUED

QUALITY

Focus Study/Quality Improvement Project: The offeror should provide the following information related to focus studies performed, and quality improvement projects and any other improvements the offeror has implemented. The offeror should copy and complete this form for each study/project identified.

Focus Study/Quality Improvement Project Implemented (title):	
Description of Study/Project:	
State/Region where Implemented:	
Date Implemented (list only activities since 2013):	
Cost Savings Realized:	
Process Efficiencies:	
Improvement to Member Health Status:	
Identification of Issues and Root Causes:	

EXHIBIT C

Exhibit C a separate link that must be downloaded separately from the Division of Purchasing and Materials Management's Internet web site at: https://www.moolb.mo.gov.

EXHIBIT D

PARTICIPATION COMMITMENT

Minority Business Enterprise/Women Business Enterprise (MBE/WBE) and/or Organization for the Blind/Sheltered Workshop and/or Service-Disabled Veteran Business Enterprise (SDVE) Participation Commitment – If the offeror is committing to participation by or if the offeror is a qualified MBE/WBE and/or organization for the blind/sheltered workshop and/or a qualified SDVE, the offeror must provide the required information in the appropriate table(s) below for the organization proposed and must submit the completed exhibit with the offeror's proposal..

For Minority Business Enterprise (MBE) and/or Woman Business Enterprise (WBE) Participation, if proposing an entity certified as both MBE and WBE, the offeror must either (1) enter the participation percentage under MBE or WBE, **or** must (2) divide the participation between both MBE and WBE. If dividing the participation, do not state the total participation on both the MBE and WBE Participation Commitment tables below. Instead, divide the total participation as proportionately appropriate between the tables below.

MBE Participation Commitment Table		
(The services performed or the products provided by the listed MBE must provide a commercially useful function related to the delivery of the contractually-required service/product in a manner that will constitute an added value to the contract and shall be performed/provided exclusive to the performance of the contract.)		
Name of Each Qualified Minority Business Enterprise (MBE) Proposed	**Committed Percentage of Participation for Each MBE** (% of the Actual Total Contract Value)	**Description of Products/Services to be Provided by Listed MBE** *The offeror should also include the paragraph number(s) from the RFP which requires the product/service the MBE is proposed to perform and describe how the proposed product/service constitutes added value and will be exclusive to the contract.*
1.	%	Product/Service(s) proposed: RFP Paragraph References:
2.	%	Product/Service(s) proposed: RFP Paragraph References:
3.	%	Product/Service(s) proposed: RFP Paragraph References:
4.	%	Product/Service(s) proposed: RFP Paragraph References:
Total MBE Percentage:	**%**	

WBE Participation Commitment Table		
(The services performed or the products provided by the listed WBE must provide a commercially useful function related to the delivery of the contractually-required service/product in a manner that will constitute an added value to the contract and shall be performed/provided exclusive to the performance of the contract.)		
Name of Each Qualified Women Business Enterprise (WBE) proposed	**Committed Percentage of Participation for Each WBE** (% of the Actual Total Contract Value)	**Description of Products/Services to be Provided by Listed WBE** *The offeror should also include the paragraph number(s) from the RFP which requires the product/service the WBE is proposed to perform and describe how the proposed product/service constitutes added value and will be exclusive to the contract.*
1.	%	Product/Service(s) proposed: RFP Paragraph References:
2.	%	Product/Service(s) proposed: RFP Paragraph References:
3.	%	Product/Service(s) proposed: RFP Paragraph References:
4.	%	Product/Service(s) proposed: RFP Paragraph References:
Total WBE Percentage:	**%**	

Organization for the Blind/Sheltered Workshop Commitment Table	
By completing this table, the offeror commits to the use of the organization at the greater of $5,000 or 2% of the actual total dollar value of contract.	
(The services performed or the products provided by the listed Organization for the Blind/Sheltered Workshop must provide a commercially useful function related to the delivery of the contractually-required service/product in a manner that will constitute an added value to the contract and shall be performed/provided exclusive to the performance of the contract.)	
Name of Organization for the Blind or Sheltered Workshop Proposed	**Description of Products/Services to be Provided by Listed Organization for the Blind/Sheltered Workshop** *The offeror should also include the paragraph number(s) from the RFP which requires the product/service the organization for the blind/sheltered workshop is proposed to perform and describe how the proposed product/service constitutes added value and will be exclusive to the contract.*
1.	Product/Service(s) proposed: RFP Paragraph References:
2.	Product/Service(s) proposed: RFP Paragraph References:

SDVE Participation Commitment Table		
(The services performed or the products provided by the listed SDVE must provide a commercially useful function related to the delivery of the contractually-required service/product in a manner that will constitute an added value to the contract and shall be performed/provided exclusive to the performance of the contract.)		
Name of Each Qualified Service-Disabled Veteran Business Enterprise (SDVE) Proposed	**Committed Percentage of Participation for Each SDVE** (% of the Actual Total Contract Value)	**Description of Products/Services to be Provided by Listed SDVE** *The offeror should also include the paragraph number(s) from the RFP which requires the product/service the SDVE is proposed to perform and describe how the proposed product/service constitutes added value and will be exclusive to the contract.*
1.	%	Product/Service(s) proposed: RFP Paragraph References:
2.	%	Product/Service(s) proposed: RFP Paragraph References:
Total SDVE Percentage:	**%**	

EXHIBIT E

DOCUMENTATION OF INTENT TO PARTICIPATE

If the offeror is proposing to include the participation of a Minority Business Enterprise/Women Business Enterprise (MBE/WBE) and/or Organization for the Blind/Sheltered Workshop and/or qualified Service-Disabled Veteran Business Enterprise (SDVE) in the provision of the products/services required in the RFP, the offeror must either provide a recently dated letter of intent, signed and dated no earlier than the RFP issuance date, from each organization documenting the following information, or complete and provide this Exhibit with the offeror's proposal.

~ Copy This Form For Each Organization Proposed ~

Offeror Name: _____

This Section To Be Completed by Participating Organization:

By completing and signing this form, the undersigned hereby confirms the intent of the named participating organization to provide the products/services identified herein for the offeror identified above.

Indicate appropriate business classification(s):

____ MBE ____ WBE ____ Organization for the Blind ____ Sheltered Workshop ____ SDVE

Name of Organization: _____
(Name of MBE, WBE, Organization for the Blind, Sheltered Workshop, or SDVE)

Contact Name:	_____	Email:	_____
Address (If SDVE, provide MO Address):	_____	Phone #:	_____
City:	_____	Fax #:	_____
State/Zip:	_____	Certification #	_____
SDVE's Website Address:	_____	Certification Expiration Date:	(or attach copy of certification) _____
Service-Disabled Veteran's (SDV) Name: (Please Print)	_____	SDV's Signature:	_____

PRODUCTS/SERVICES PARTICIPATING ORGANIZATION AGREED TO PROVIDE

Describe the products/services you *(as the participating organization)* have agreed to provide:

_____

_____

_____

Authorized Signature:

_____	_____
Authorized Signature of Participating Organization (MBE, WBE, Organization for the Blind, Sheltered Workshop, or SDVE)	*Date (Dated no earlier than the RFP issuance date)*

EXHIBIT E (continued)

DOCUMENTATION OF INTENT TO PARTICIPATE

SERVICE-DISABLED VETERAN BUSINESS ENTERPRISE (SDVE)

If a participating organization is an SDVE, unless the Service-Disabled Veteran (SDV) documents were previously submitted within the past five (5) years to the Division of Purchasing and Materials Management (DPMM), the offeror **must** provide the following SDV documents:

- a copy of the SDV's award letter from the Department of Veterans Affairs or a copy of the SDV's discharge paper (DD Form 214, Certificate of Release or Discharge from Active Duty), AND
- a copy of the SDV's documentation certifying disability by the appropriate federal agency responsible for the administration of veterans' affairs.

(NOTE: The SDV's award letter, the SDV's discharge paper, and the SDV's documentation certifying disability shall be considered confidential pursuant to subsection 14 of section 610.021, RSMo.)

The offeror should check the appropriate statement below and, if applicable, provide the requested information.

❒ No, I have not previously submitted the SDV documents specified above to the DPMM and therefore have enclosed the SDV documents.

❒ Yes, I previously submitted the SDV documents specified above within the past five (5) years to the DPMM.

Date SDV Documents were Submitted: _____

Previous **Proposal/Contract Number** for Which the SDV Documents were Submitted: _____
(if applicable and known)

(NOTE: If the proposed SDVE and SDV are listed on the DPMM SDVE database located at http://content.oa.mo.gov/sites/default/files/sdvelisting.pdf, then the SDV documents have been submitted to the DPMM within the past five [5] years. However, if it has been determined that an SDVE at any time no longer meets the requirements stated above, the DPMM will remove the SDVE and associated SDV from the database.)

FOR STATE USE ONLY

SDV Documents - Verification Completed By:

_____ _____
Buyer Date

EXHIBIT F

BUSINESS ENTITY CERTIFICATION, ENROLLMENT DOCUMENTATION, AND AFFIDAVIT OF WORK AUTHORIZATION

BUSINESS ENTITY CERTIFICATION:
The offeror must certify their current business status by completing either Box A or Box B or Box C on this Exhibit.

BOX A:	To be completed by a non-business entity as defined below.
BOX B:	To be completed by a business entity who has not yet completed and submitted documentation pertaining to the federal work authorization program as described at http://www.dhs.gov/files/programs/gc_1185221678150.shtm.
BOX C:	To be completed by a business entity who has current work authorization documentation on file with a Missouri state agency including Division of Purchasing and Materials Management.

Business entity, as defined in section 285.525, RSMo, pertaining to section 285.530, RSMo, is any person or group of persons performing or engaging in any activity, enterprise, profession, or occupation for gain, benefit, advantage, or livelihood. The term "**business entity**" shall include but not be limited to self-employed individuals, partnerships, corporations, contractors, and subcontractors. The term "**business entity**" shall include any business entity that possesses a business permit, license, or tax certificate issued by the state, any business entity that is exempt by law from obtaining such a business permit, and any business entity that is operating unlawfully without such a business permit. The term "**business entity**" shall not include a self-employed individual with no employees or entities utilizing the services of direct sellers as defined in subdivision (17) of subsection 12 of section 288.034, RSMo.

Note: Regarding governmental entities, business entity includes Missouri schools, Missouri universities (other than stated in Box C), out of state agencies, out of state schools, out of state universities, and political subdivisions. A business entity does not include Missouri state agencies and federal government entities.

BOX A – CURRENTLY NOT A BUSINESS ENTITY

I certify that _____ (Company/Individual Name) **DOES NOT CURRENTLY MEET** the definition of a business entity, as defined in section 285.525, RSMo pertaining to section 285.530, RSMo as stated above, because: (check the applicable business status that applies below)

☐ - I am a self-employed individual with no employees; **OR**

☐ - The company that I represent employs the services of direct sellers as defined in subdivision (17) of subsection 12 of section 288.034, RSMo.

I certify that I am not an alien unlawfully present in the United States and if _____ (Company/Individual Name) is awarded a contract for the services requested herein under _____ (RFP Number) and if the business status changes during the life of the contract to become a business entity as defined in section 285.525, RSMo pertaining to section 285.530, RSMo then, prior to the performance of any services as a business entity, _____ (Company/Individual Name) agrees to complete Box B, comply with the requirements stated in Box B and provide the Division of Purchasing and Materials Management with all documentation required in Box B of this exhibit.

Authorized Representative's Name (Please Print)	*Authorized Representative's Signature*
Company Name (if applicable)	Date

EXHIBIT F, continued

(Complete the following if you DO NOT have the E-Verify documentation and a current Affidavit of Work Authorization already on file with the State of Missouri. If completing Box B, do not complete Box C.)

BOX B – CURRENT BUSINESS ENTITY STATUS

I certify that _____ (Business Entity Name) **MEETS** the definition of a business entity as defined in section 285.525, RSMo pertaining to section 285.530.

Authorized Business Entity Representative's Name (Please Print)	*Authorized Business Entity Representative's Signature*
Business Entity Name	Date
E-Mail Address	

As a business entity, the offeror must perform/provide each of the following. The offeror should check each to verify completion/submission of all of the following:

☐ - Enroll and participate in the E-Verify federal work authorization program (Website: http://www.dhs.gov/files/programs/gc_1185221678150.shtm; Phone: 888-464-4218; Email: e-verify@dhs.gov) with respect to the employees hired after enrollment in the program who are proposed to work in connection with the services required herein;

AND

☐ - Provide documentation affirming said company's/individual's enrollment and participation in the E-Verify federal work authorization program. Documentation shall include EITHER the E-Verify Employment Eligibility Verification page listing the offeror's name and company ID OR a page from the E-Verify Memorandum of Understanding (MOU) listing the offeror's name and the MOU signature page completed and signed, at minimum, by the offeror and the Department of Homeland Security – Verification Division. If the signature page of the MOU lists the offeror's name and company ID, then no additional pages of the MOU must be submitted;

AND

☐ - Submit a completed, notarized Affidavit of Work Authorization provided on the next page of this Exhibit.

EXHIBIT F, continued

AFFIDAVIT OF WORK AUTHORIZATION:

The offeror who meets the section 285.525, RSMo, definition of a business entity must complete and return the following Affidavit of Work Authorization.

Comes now _____ (Name of Business Entity Authorized Representative) as _____ (Position/Title) first being duly sworn on my oath, affirm _____ (Business Entity Name) is enrolled and will continue to participate in the E-Verify federal work authorization program with respect to employees hired after enrollment in the program who are proposed to work in connection with the services related to contract(s) with the State of Missouri for the duration of the contract(s), if awarded in accordance with subsection 2 of section 285.530, RSMo. I also affirm that _____ (Business Entity Name) does not and will not knowingly employ a person who is an unauthorized alien in connection with the contracted services provided under the contract(s) for the duration of the contract(s), if awarded.

In Affirmation thereof, the facts stated above are true and correct. (The undersigned understands that false statements made in this filing are subject to the penalties provided under section 575.040, RSMo.)

Authorized Representative's Signature	Printed Name
Title	Date
E-Mail Address	E-Verify Company ID Number

Subscribed and sworn to before me this _____ (DAY) of _____ (MONTH, YEAR). I am commissioned as a notary public within the County of _____ (NAME OF COUNTY), State of _____ (NAME OF STATE), and my commission expires on _____ (DATE).

Signature of Notary	*Date*

EXHIBIT F, continued

(Complete the following if you have the E-Verify documentation and a current Affidavit of Work Authorization already on file with the State of Missouri. If completing Box C, do not complete Box B.)

BOX C – AFFIDAVIT ON FILE - CURRENT BUSINESS ENTITY STATUS

I certify that _____ (Business Entity Name) **MEETS** the definition of a business entity as defined in section 285.525, RSMo pertaining to section 285.530, RSMo and have enrolled and currently participates in the E-Verify federal work authorization program with respect to the employees hired after enrollment in the program who are proposed to work in connection with the services related to contract(s) with the State of Missouri. We have previously provided documentation to a Missouri state agency or public university that affirms enrollment and participation in the E-Verify federal work authorization program. The documentation that was previously provided included the following.

- ✓ The E-Verify Employment Eligibility Verification page OR a page from the E-Verify Memorandum of Understanding (MOU) listing the offeror's name and the MOU signature page completed and signed by the offeror and the Department of Homeland Security – Verification Division
- ✓ A current, notarized Affidavit of Work Authorization (must be completed, signed, and notarized within the past twelve months).

Name of **Missouri State Agency** or **Public University*** to Which Previous E-Verify Documentation Submitted: _____

(*Public University includes the following five schools under chapter 34, RSMo: Harris-Stowe State University – St. Louis; Missouri Southern State University – Joplin; Missouri Western State University – St. Joseph; Northwest Missouri State University – Maryville; Southeast Missouri State University – Cape Girardeau.)

Date of Previous E-Verify Documentation Submission: _____

Previous **Bid/Contract Number** for Which Previous E-Verify Documentation Submitted: _____ (if known)

Authorized Business Entity Representative's Name (Please Print)	*Authorized Business Entity Representative's Signature*
Business Entity Name	Date
E-Mail Address	E-Verify MOU Company ID Number

FOR STATE OF MISSOURI USE ONLY

Documentation Verification Completed By:

Buyer	Date

EXHIBIT G

Certification Regarding
Debarment, Suspension, Ineligibility and Voluntary Exclusion
Lower Tier Covered Transactions

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, 29 CFR Part 98 Section 98.510, Participants' responsibilities. The regulations were published as Part VII of the May 26, 1988, Federal Register (pages 19160-19211).

(BEFORE COMPLETING CERTIFICATION, READ INSTRUCTIONS FOR CERTIFICATION)

(1) The prospective recipient of Federal assistance funds certifies, by submission of this proposal, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

(2) Where the prospective recipient of Federal assistance funds is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Company Name	DUNS # (if known)
Authorized Representative's Printed Name	Authorized Representative's Title
Authorized Representative's Signature	Date

Instructions for Certification

1. By signing and submitting this proposal, the prospective recipient of Federal assistance funds is providing the certification as set out below.
2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective recipient of Federal assistance funds knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the Department of Labor (DOL) may pursue available remedies, including suspension and/or debarment.
3. The prospective recipient of Federal assistance funds shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective recipient of Federal assistance funds learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.
5. The prospective recipient of Federal assistance funds agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the DOL.
6. The prospective recipient of Federal assistance funds further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may but is not required to check the List of Parties Excluded from Procurement or Nonprocurement Programs.
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntary excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the DOL may pursue available remedies, including suspension and/or debarment.

AMENDMENT 1 REVISED EXHIBIT H:

EXHIBIT H

MISCELLANEOUS INFORMATION

AMENDMENT 1 REVISED THE FOLLOWING ITEM OF EXHIBIT H:

Outside United States - If any products and/or services offered under this RFP are being manufactured or performed at sites outside the United States, the offeror MUST disclose such fact and provide details in the space below or on an attached page.

Are any of the offeror's proposed products and/or services being manufactured or performed at sites outside the United States?	Yes ____	No ____
If YES, do the proposed products/services satisfy the conditions described in Section 4, subparagraphs 1, 2, 3, and 4 of Executive Order 04-09? (see the following web link: http://www.sos.mo.gov/library/reference/orders/2004/eo04_009.asp)	Yes ____	No ____

If YES, mark the appropriate exemption below, and provide the requested details:

1. ____ Unique good or service.
   - EXPLAIN:_____
2. ____ Foreign firm hired to market Missouri services/products to a foreign country.
   - Identify foreign country: _____
3. ____ Economic cost factor exists
   - EXPLAIN:_____
4. ____ Vendor/subcontractor maintains significant business presence in the United States and only performs trivial portion of contract work outside US.
   - Identify maximum percentage of the overall value of the contract, for any contract period, attributed to the value of the products and/or services being manufactured or performed at sites outside the United States: ___%
   - Specify what contract work would be performed outside the United States: _____

Employee/Conflict of Interest:

Offerors who are elected or appointed officials or employees of the State of Missouri or any political subdivision thereof, serving in an executive or administrative capacity, must comply with sections 105.450 to 105.458, RSMo, regarding conflict of interest. If the offeror or any owner of the offeror's organization is currently an elected or appointed official or an employee of the State of Missouri or any political subdivision thereof, please provide the following information:	
Name and title of elected or appointed official or employee of the State of Missouri or any political subdivision thereof:	
If employee of the State of Missouri or political subdivision thereof, provide name of state agency or political subdivision where employed:	
Percentage of ownership interest in offeror's organization held by elected or appointed official or employee of the State of Missouri or political subdivision thereof:	_____%

ATTACHMENTS

The Attachments are a separate link that must be downloaded separately from the Division of Purchasing and Materials Management's Internet web site at: https://www.moolb.mo.gov.

STATE OF MISSOURI
DIVISION OF PURCHASING AND MATERIALS MANAGEMENT
TERMS AND CONDITIONS -- REQUEST FOR PROPOSAL

1. TERMINOLOGY/DEFINITIONS

Whenever the following words and expressions appear in a Request for Proposal (RFP) document or any amendment thereto, the definition or meaning described below shall apply.

a. **Agency and/or State Agency** means the statutory unit of state government in the State of Missouri for which the equipment, supplies, and/or services are being purchased by the **Division of Purchasing and Materials Management (DPMM)**. The agency is also responsible for payment.
b. **Amendment** means a written, official modification to an RFP or to a contract.
c. **Attachment** applies to all forms which are included with an RFP to incorporate any informational data or requirements related to the performance requirements and/or specifications.
d. **Proposal Opening Date and Time** and similar expressions mean the exact deadline required by the RFP for the receipt of sealed proposals.
e. **Offeror** means the person or organization that responds to an RFP by submitting a proposal with prices to provide the equipment, supplies, and/or services as required in the RFP document.
f. **Buyer** means the procurement staff member of the DPMM. The **Contact Person** as referenced herein is usually the Buyer.
g. **Contract** means a legal and binding agreement between two or more competent parties, for a consideration for the procurement of equipment, supplies, and/or services.
h. **Contractor** means a person or organization who is a successful offeror as a result of an RFP and who enters into a contract.
i. **Exhibit** applies to forms which are included with an RFP for the offeror to complete and submit with the sealed proposal prior to the specified opening date and time.
j. **Request for Proposal (RFP)** means the solicitation document issued by the DPMM to potential offerors for the purchase of equipment, supplies, and/or services as described in the document. The definition includes these Terms and Conditions as well as all Pricing Pages, Exhibits, Attachments, and Amendments thereto.
k. **May** means that a certain feature, component, or action is permissible, but not required.
l. **Must** means that a certain feature, component, or action is a mandatory condition.
m. **Pricing Page(s)** applies to the form(s) on which the offeror must state the price(s) applicable for the equipment, supplies, and/or services required in the RFP. The pricing pages must be completed and submitted by the offeror with the sealed proposal prior to the specified proposal opening date and time.
n. **RSMo (Revised Statutes of Missouri)** refers to the body of laws enacted by the Legislature which govern the operations of all agencies of the State of Missouri. Chapter 34 of the statutes is the primary chapter governing the operations of DPMM.
o. **Shall** has the same meaning as the word must.
p. **Should** means that a certain feature, component and/or action is desirable but not mandatory.

2. APPLICABLE LAWS AND REGULATIONS

a. The contract shall be construed according to the laws of the State of Missouri. The contractor shall comply with all local, state, and federal laws and regulations related to the performance of the contract to the extent that the same may be applicable.
b. To the extent that a provision of the contract is contrary to the Constitution or laws of the State of Missouri or of the United States, the provisions shall be void and unenforceable. However, the balance of the contract shall remain in force between the parties unless terminated by consent of both the contractor and the DPMM.
c. The contractor must be registered and maintain good standing with the Secretary of State of the State of Missouri and other regulatory agencies, as may be required by law or regulations.
d. The contractor must timely file and pay all Missouri sales, withholding, corporate and any other required Missouri tax returns and taxes, including interest and additions to tax.
e. The exclusive venue for any legal proceeding relating to or arising out of the RFP or resulting contract shall be in the Circuit Court of Cole County, Missouri.
f. The contractor shall only employ personnel authorized to work in the United States in accordance with applicable federal and state laws and Executive Order 07-13 for work performed in the United States.

3. OPEN COMPETITION/REQUEST FOR PROPOSAL DOCUMENT

a. It shall be the offeror's responsibility to ask questions, request changes or clarification, or otherwise advise the DPMM if any language, specifications or requirements of an RFP appear to be ambiguous, contradictory, and/or arbitrary, or appear to inadvertently restrict or limit the requirements stated in the RFP to a single source. Any and all communication from offerors regarding specifications, requirements, competitive proposal process, etc., must be directed to the buyer from the DPMM, unless the RFP specifically refers the offeror to another contact. Such e-mail, fax, or phone communication should be received at least ten calendar days prior to the official proposal opening date.
b. Every attempt shall be made to ensure that the offeror receives an adequate and prompt response. However, in order to maintain a fair and equitable procurement process, all offerors will be advised, via the issuance of an amendment to the RFP, of any relevant or pertinent information related to the procurement. Therefore, offerors are advised that unless specified elsewhere in the RFP, any questions received less than ten calendar days prior to the RFP opening date may not be answered.
c. Offerors are cautioned that the only official position of the State of Missouri is that which is issued by the DPMM in the RFP or an amendment thereto. No other means of communication, whether oral or written, shall be construed as a formal or official response or statement.
d. The DPMM monitors all procurement activities to detect any possibility of deliberate restraint of competition, collusion among offerors, price-fixing by offerors, or any other anticompetitive conduct by offerors which appears to violate state and federal antitrust laws. Any suspected violation shall be referred to the Missouri Attorney General's Office for appropriate action.
e. The RFP is available for viewing and downloading on the state's On-Line Bidding/Vendor Registration System website. Registered offerors are electronically notified of the proposal opportunity based on the information maintained in the State of Missouri's vendor database. If a registered offeror's e-mail address is incorrect, the offeror must update the e-mail address themselves on the state's On-Line Bidding/Vendor Registration System website.
f. The DPMM reserves the right to officially amend or cancel an RFP after issuance. It shall be the sole responsibility of the offeror to monitor the State of Missouri On-Line Bidding/Vendor Registration System website at: https://www.moolb.mo.gov to obtain a copy of the amendment(s). Registered offerors who received e-mail notification of the proposal opportunity when the RFP was established and registered offerors who have responded to the RFP on-line prior to an amendment being issued will receive e-mail notification of the amendment(s). Registered offerors who received e-mail notification of the proposal opportunity when the RFP was established and registered offerors who have responded to the proposal on-line prior to a cancellation being issued will receive e-mail notification of a cancellation issued prior to the exact closing time and date specified in the RFP.

4. PREPARATION OF PROPOSALS

a. Offerors **must** examine the entire RFP carefully. Failure to do so shall be at offeror's risk.

b. Unless otherwise specifically stated in the RFP, all specifications and requirements constitute minimum requirements. All proposals must meet or exceed the stated specifications and requirements.
c. Unless otherwise specifically stated in the RFP, any manufacturer names, trade names, brand names, information and/or catalog numbers listed in a specification and/or requirement are for informational purposes only and are not intended to limit competition. The offeror may offer any brand which meets or exceeds the specification for any item, but must state the manufacturer's name and model number for any such brands in the proposal. In addition, the offeror shall explain, in detail, (1) the reasons why the proposed equivalent meets or exceeds the specifications and/or requirements and (2) why the proposed equivalent should not be considered an exception thereto. Proposals which do not comply with the requirements and specifications are subject to rejection without clarification.
d. Proposals lacking any indication of intent to offer an alternate brand or to take an exception shall be received and considered in complete compliance with the specifications and requirements as listed in the RFP.
e. In the event that the offeror is an agency of state government or other such political subdivision which is prohibited by law or court decision from complying with certain provisions of an RFP, such an offeror may submit a proposal which contains a list of statutory limitations and identification of those prohibitive clauses. The offeror should include a complete list of statutory references and citations for each provision of the RFP, which is affected by this paragraph. The statutory limitations and prohibitive clauses may (1) be requested to be clarified in writing by DPMM or (2) be accepted without further clarification if the statutory limitations and prohibitive clauses are deemed acceptable by DPMM. If DPMM determines clarification of the statutory limitations and prohibitive clauses is necessary, the clarification will be conducted in order to agree to language that reflects the intent and compliance of such law and/or court order and the RFP.
f. All equipment and supplies offered in a proposal must be new, of current production, and available for marketing by the manufacturer unless the RFP clearly specifies that used, reconditioned, or remanufactured equipment and supplies may be offered.
g. Prices shall include all packing, handling and shipping charges FOB destination, freight prepaid and allowed unless otherwise specified in the RFP.
h. Proposals, including all prices therein, shall remain valid for 90 days from proposal opening or Best and Final Offer (BAFO) submission unless otherwise indicated. If the proposal is accepted, the entire proposal, including all prices, shall be firm for the specified contract period.
i. Any foreign offeror not having an Employer Identification Number assigned by the United States Internal Revenue Service (IRS) must submit a completed IRS Form W-8 prior to or with the submission of their proposal in order to be considered for award.

5. SUBMISSION OF PROPOSALS

a. Proposals may be submitted by delivery of a hard copy to the DPMM office. Electronic submission of proposals by registered offerors through the State of Missouri's On-Line Bidding/Vendor Registration System website is not available unless stipulated in the RFP. Delivered proposals must be sealed in an envelope or container, and received in the DPMM office located at 301 West High St, Rm 630 in Jefferson City, MO no later than the exact opening time and date specified in the RFP. All proposals must (1) be submitted by a duly authorized representative of the offeror's organization, (2) contain all information required by the RFP, and (3) be priced as required. Hard copy proposals may be mailed to the DPMM post office box address. However, it shall be the responsibility of the offeror to ensure their proposal is in the DPMM office (address listed above) no later than the exact opening time and date specified in the RFP.
b. The sealed envelope or container containing a proposal should be clearly marked on the outside with (1) the official RFP number and (2) the official opening date and time. Different proposals should not be placed in the same envelope, although copies of the same proposal may be placed in the same envelope.
c. A proposal submitted electronically by a registered offeror may be modified on-line prior to the official opening date and time. A proposal which has been delivered to the DPMM office may be modified by signed, written notice which has been received by the DPMM prior to the official opening date and time specified. A proposal may also be modified in person by the offeror or its authorized representative, provided proper identification is presented before the official opening date and time. Telephone or telegraphic requests to modify a proposal shall not be honored.
d. A proposal submitted electronically by a registered offeror may be canceled on-line prior to the official opening date and time. A proposal which has been delivered to the DPMM office may only be withdrawn by a signed, written document on company letterhead transmitted via mail, e-mail, or facsimile which has been received by the DPMM prior to the official opening date and time specified. A proposal may also be withdrawn in person by the offeror or its authorized representative, provided proper identification is presented before the official opening date and time. Telephone or telegraphic requests to withdraw a proposal shall not be honored.
e. A proposal may also be withdrawn after the proposal opening through submission of a written request by an authorized representative of the offeror. Justification of withdrawal decision may include a significant error or exposure of proposal information that may cause irreparable harm to the offeror.
f. When submitting a proposal electronically, the registered offeror indicates acceptance of all RFP terms and conditions by clicking on the "Submit" button on the Electronic Bid Response Entry form. Offerors delivering a hard copy proposal to DPMM must sign and return the RFP cover page or, if applicable, the cover page of the last amendment thereto in order to constitute acceptance by the offeror of all RFP terms and conditions. Failure to do so may result in rejection of the proposal unless the offeror's full compliance with those documents is indicated elsewhere within the offeror's response.
g. Faxed proposals shall not be accepted. However, faxed and e-mail no-bid notifications shall be accepted.

6. PROPOSAL OPENING

a. Proposal openings are public on the opening date and at the opening time specified on the RFP document. Only the names of the respondents shall be read at the proposal opening. All vendors may view the same proposal response information on the state's On-Line Bidding/Vendor Registration System website. The contents of the responses shall not be disclosed at this time.
b. Proposals which are not received in the DPMM office prior to the official opening date and time shall be considered late, regardless of the degree of lateness, and normally will not be opened. Late proposals may only be opened under extraordinary circumstances in accordance with 1 CSR 40-1.050.

7. PREFERENCES

a. In the evaluation of proposals, preferences shall be applied in accordance with chapter 34, RSMo, other applicable Missouri statutes, and applicable Executive Orders. Contractors should apply the same preferences in selecting subcontractors.
b. By virtue of statutory authority, a preference will be given to materials, products, supplies, provisions and all other articles produced, manufactured, mined, processed or grown within the State of Missouri and to all firms, corporations or individuals doing business as Missouri firms, corporations or individuals. Such preference shall be given when quality is equal or better and delivered price is the same or less.
c. In accordance with Executive Order 05-30, contractors are encouraged to utilize certified minority and women-owned businesses in selecting subcontractors.

8. EVALUATION/AWARD

a. Any clerical error, apparent on its face, may be corrected by the buyer before contract award. Upon discovering an apparent clerical error, the buyer shall contact the offeror and request clarification of the intended proposal. The correction shall be incorporated in the notice of award. Examples of apparent clerical errors are: 1) misplacement of a decimal point; and 2) obvious mistake in designation of unit.
b. Any pricing information submitted by an offeror shall be subject to evaluation if deemed by the DPMM to be in the best interest of the State of Missouri.
c. The offeror is encouraged to propose price discounts for prompt payment or propose other price discounts that would benefit the State of Missouri. However, unless otherwise specified in the RFP, pricing shall be evaluated at the maximum potential financial liability to the State of Missouri.

d. Awards shall be made to the offeror whose proposal (1) complies with all mandatory specifications and requirements of the RFP and (2) is the lowest and best proposal, considering price, responsibility of the offeror, and all other evaluation criteria specified in the RFP and any subsequent negotiations and (3) complies with chapter 34, RSMo, other applicable Missouri statutes, and all applicable Executive Orders.
e. In the event all offerors fail to meet the same mandatory requirement in an RFP, DPMM reserves the right, at its sole discretion, to waive that requirement for all offerors and to proceed with the evaluation. In addition, the DPMM reserves the right to waive any minor irregularity or technicality found in any individual proposal.
f. The DPMM reserves the right to reject any and all proposals.
g. When evaluating a proposal, the State of Missouri reserves the right to consider relevant information and fact, whether gained from a proposal, from an offeror, from offeror's references, or from any other source.
h. Any information submitted with the proposal, regardless of the format or placement of such information, may be considered in making decisions related to the responsiveness and merit of a proposal and the award of a contract.
i. Negotiations may be conducted with those offerors who submit potentially acceptable proposals. Proposal revisions may be permitted for the purpose of obtaining best and final offers. In conducting negotiations, there shall be no disclosure of any information submitted by competing offerors.
j. Any award of a contract shall be made by notification from the DPMM to the successful offeror. The DPMM reserves the right to make awards by item, group of items, or an all or none basis. The grouping of items awarded shall be determined by DPMM based upon factors such as item similarity, location, administrative efficiency, or other considerations in the best interest of the State of Missouri.
k. Pursuant to section 610.021, RSMo, proposals and related documents shall not be available for public review until after a contract is executed or all proposals are rejected.
l. The DPMM posts all proposal results on the On-line Bidding/Vendor Registration System website for all vendors to view for a reasonable period after proposal award and maintains images of all proposal file material for review. Offerors who include an e-mail address with their proposal will be notified of the award results via e-mail.
m. The DPMM reserves the right to request clarification of any portion of the offeror's response in order to verify the intent of the offeror. The offeror is cautioned, however, that its response may be subject to acceptance or rejection without further clarification.
n. Any proposal award protest must be received within ten (10) business days after the date of award in accordance with the requirements of 1 CSR 40-1.050 (9).
o. The final determination of contract(s) award shall be made by DPMM.

9. CONTRACT/PURCHASE ORDER

a. By submitting a proposal, the offeror agrees to furnish any and all equipment, supplies and/or services specified in the RFP, at the prices quoted, pursuant to all requirements and specifications contained therein.
b. A binding contract shall consist of: (1) the RFP, amendments thereto, and any Best and Final Offer (BAFO) request(s) with RFP changes/additions, (2) the contractor's proposal including any contractor BAFO response(s), (3) clarification of the proposal, if any, and (4) DPMM's acceptance of the proposal by "notice of award" or by "purchase order." All Exhibits and Attachments included in the RFP shall be incorporated into the contract by reference.
c. A notice of award issued by the State of Missouri does not constitute an authorization for shipment of equipment or supplies or a directive to proceed with services. Before providing equipment, supplies and/or services for the State of Missouri, the contractor must receive a properly authorized purchase order or other form of authorization given to the contractor at the discretion of the state agency.
d. The contract expresses the complete agreement of the parties and performance shall be governed solely by the specifications and requirements contained therein. Any change to the contract, whether by modification and/or supplementation, must be accomplished by a formal contract amendment signed and approved by and between the duly authorized representative of the contractor and the DPMM or by a modified purchase order prior to the effective date of such modification. The contractor expressly and explicitly understands and agrees that no other method and/or no other document, including correspondence, acts, and oral communications by or from any person, shall be used or construed as an amendment or modification to the contract.

10. INVOICING AND PAYMENT

a. The State of Missouri does not pay state or federal taxes unless otherwise required under law or regulation.
b. The statewide financial management system has been designed to capture certain receipt and payment information. For each purchase order received, an invoice must be submitted that references the purchase order number and must be itemized in accordance with items listed on the purchase order. Failure to comply with this requirement may delay processing of invoices for payment.
c. The contractor shall not transfer any interest in the contract, whether by assignment or otherwise, without the prior written consent of the DPMM.
d. Payment for all equipment, supplies, and/or services required herein shall be made in arrears unless otherwise indicated in the RFP.
e. The State of Missouri assumes no obligation for equipment, supplies, and/or services shipped or provided in excess of the quantity ordered. Any unauthorized quantity is subject to the state's rejection and shall be returned at the contractor's expense.
f. All invoices for equipment, supplies, and/or services purchased by the State of Missouri shall be subject to late payment charges as provided in section 34.055, RSMo.
g. The State of Missouri reserves the right to purchase goods and services using the state purchasing card.

11. DELIVERY

Time is of the essence. Deliveries of equipment, supplies, and/or services must be made no later than the time stated in the contract or within a reasonable period of time, if a specific time is not stated.

12. INSPECTION AND ACCEPTANCE

a. No equipment, supplies, and/or services received by an agency of the state pursuant to a contract shall be deemed accepted until the agency has had reasonable opportunity to inspect said equipment, supplies, and/or services.
b. All equipment, supplies, and/or services which do not comply with the specifications and/or requirements or which are otherwise unacceptable or defective may be rejected. In addition, all equipment, supplies, and/or services which are discovered to be defective or which do not conform to any warranty of the contractor upon inspection (or at any later time if the defects contained were not reasonably ascertainable upon the initial inspection) may be rejected.
c. The State of Missouri reserves the right to return any such rejected shipment at the contractor's expense for full credit or replacement and to specify a reasonable date by which replacements must be received.
d. The State of Missouri's right to reject any unacceptable equipment, supplies, and/or services shall not exclude any other legal, equitable or contractual remedies the state may have.

13. WARRANTY

a. The contractor expressly warrants that all equipment, supplies, and/or services provided shall: (1) conform to each and every specification, drawing, sample or other description which was furnished to or adopted by the DPMM, (2) be fit and sufficient for the purpose expressed in the RFP, (3) be merchantable, (4) be of good materials and workmanship, and (5) be free from defect.
b. Such warranty shall survive delivery and shall not be deemed waived either by reason of the state's acceptance of or payment for said equipment, supplies, and/or services.

14. CONFLICT OF INTEREST

a. Elected or appointed officials or employees of the State of Missouri or any political subdivision thereof, serving in an executive or administrative capacity, must comply with sections 105.452 and 105.454, RSMo, regarding conflict of interest.
b. The contractor hereby covenants that at the time of the submission of the proposal the contractor has no other contractual relationships which would create any actual or perceived conflict of interest. The contractor further agrees that during the term of the contract neither the contractor nor any of its employees shall acquire any other contractual relationships which create such a conflict.

15. REMEDIES AND RIGHTS

a. No provision in the contract shall be construed, expressly or implied, as a waiver by the State of Missouri of any existing or future right and/or remedy available by law in the event of any claim by the State of Missouri of the contractor's default or breach of contract.
b. The contractor agrees and understands that the contract shall constitute an assignment by the contractor to the State of Missouri of all rights, title and interest in and to all causes of action that the contractor may have under the antitrust laws of the United States or the State of Missouri for which causes of action have accrued or will accrue as the result of or in relation to the particular equipment, supplies, and/or services purchased or procured by the contractor in the fulfillment of the contract with the State of Missouri.

16. CANCELLATION OF CONTRACT

a. In the event of material breach of the contractual obligations by the contractor, the DPMM may cancel the contract. At its sole discretion, the DPMM may give the contractor an opportunity to cure the breach or to explain how the breach will be cured. The actual cure must be completed within no more than 10 working days from notification, or at a minimum the contractor must provide DPMM within 10 working days from notification a written plan detailing how the contractor intends to cure the breach.
b. If the contractor fails to cure the breach or if circumstances demand immediate action, the DPMM will issue a notice of cancellation terminating the contract immediately. If it is determined the DPMM improperly cancelled the contract, such cancellation shall be deemed a termination for convenience in accordance with the contract.
c. If the DPMM cancels the contract for breach, the DPMM reserves the right to obtain the equipment, supplies, and/or services to be provided pursuant to the contract from other sources and upon such terms and in such manner as the DPMM deems appropriate and charge the contractor for any additional costs incurred thereby.
d. The contractor understands and agrees that funds required to fund the contract must be appropriated by the General Assembly of the State of Missouri for each fiscal year included within the contract period. The contract shall not be binding upon the state for any period in which funds have not been appropriated, and the state shall not be liable for any costs associated with termination caused by lack of appropriations.

17. COMMUNICATIONS AND NOTICES

Any notice to the offeror/contractor shall be deemed sufficient when deposited in the United States mail postage prepaid, transmitted by facsimile, transmitted by e-mail or hand-carried and presented to an authorized employee of the offeror/contractor.

18. BANKRUPTCY OR INSOLVENCY

a. Upon filing for any bankruptcy or insolvency proceeding by or against the contractor, whether voluntary or involuntary, or upon the appointment of a receiver, trustee, or assignee for the benefit of creditors, the contractor must notify the DPMM immediately.
b. Upon learning of any such actions, the DPMM reserves the right, at its sole discretion, to either cancel the contract or affirm the contract and hold the contractor responsible for damages.

19. INVENTIONS, PATENTS AND COPYRIGHTS

The contractor shall defend, protect, and hold harmless the State of Missouri, its officers, agents, and employees against all suits of law or in equity resulting from patent and copyright infringement concerning the contractor's performance or products produced under the terms of the contract.

20. NON-DISCRIMINATION AND AFFIRMATIVE ACTION

In connection with the furnishing of equipment, supplies, and/or services under the contract, the contractor and all subcontractors shall agree not to discriminate against recipients of services or employees or applicants for employment on the basis of race, color, religion, national origin, sex, age, disability, or veteran status unless otherwise provided by law. If the contractor or subcontractor employs at least 50 persons, they shall have and maintain an affirmative action program which shall include:

a. A written policy statement committing the organization to affirmative action and assigning management responsibilities and procedures for evaluation and dissemination;
b. The identification of a person designated to handle affirmative action;
c. The establishment of non-discriminatory selection standards, objective measures to analyze recruitment, an upward mobility system, a wage and salary structure, and standards applicable to layoff, recall, discharge, demotion, and discipline;
d. The exclusion of discrimination from all collective bargaining agreements; and
e. Performance of an internal audit of the reporting system to monitor execution and to provide for future planning.

If discrimination by a contractor is found to exist, the DPMM shall take appropriate enforcement action which may include, but not necessarily be limited to, cancellation of the contract, suspension, or debarment by the DPMM until corrective action by the contractor is made and ensured, and referral to the Attorney General's Office, whichever enforcement action may be deemed most appropriate.

21. AMERICANS WITH DISABILITIES ACT

In connection with the furnishing of equipment, supplies, and/or services under the contract, the contractor and all subcontractors shall comply with all applicable requirements and provisions of the Americans with Disabilities Act (ADA).

22. FILING AND PAYMENT OF TAXES

The commissioner of administration and other agencies to which the state purchasing law applies shall not contract for goods or services with a vendor if the vendor or an affiliate of the vendor makes sales at retail of tangible personal property or for the purpose of storage, use, or consumption in this state but fails to collect and properly pay the tax as provided in chapter 144, RSMo. For the purposes of this section, "affiliate of the vendor" shall mean any person or entity that is controlled by or is under common control with the vendor, whether through stock ownership or otherwise. Therefore offeror's failure to maintain compliance with chapter 144, RSMo, may eliminate their proposal from consideration for award.

23. TITLES

Titles of paragraphs used herein are for the purpose of facilitating reference only and shall not be construed to infer a contractual construction of language.

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