STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING (PURCHASING)
REQUEST FOR PROPOSAL (RFP)

ADDENDUM NO.: 03
SOLICITATION/OPPORTUNITY (OPP) NO.: RFPS30034902200777
TITLE: MO HealthNet Managed Care Program
ISSUE DATE: December 30, 2021

REQ NO.: RX012200028
BUYER: Megan Howser
PHONE NO.: (573) 751-1686
E-MAIL: megan.howser@oa.mo.gov

RETURN PROPOSAL NO LATER THAN: January 12, 2022 AT 2:00 PM CENTRAL TIME (END DATE)

RFP RESPONSE MUST BE SUBMITTED ELECTRONICALLY THROUGH MISSOURIBUYS. MAILED, COURIER, OR HAND-DELIVERED RFP RESPONSE WILL NOT BE ACCEPTED.

VENDORS MUST RESPOND ELECTRONICALLY THROUGH HTTPS://MISSOURIBUYS.MO.GOV

CONTRACT PERIOD: Effective Date of Contract through One Year

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

Missouri Department of Social Services
MO HealthNet Division
615 Howerton Court, PO Box 6500
Jefferson City, MO 65102-6500

The vendor 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 addendums. The vendor should, as a matter of clarity and assurance, also sign and return all previously issued RFP addendum(s) and the original RFP document. The vendor agrees that the language of the original RFP as modified by this and any previously issued RFP addendums shall govern in the event of a conflict with his/her proposal. The vendor further agrees that upon receipt of an authorized purchase order from the Division of Purchasing 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 vendor and the State of Missouri. The vendor shall understand and agree that in order for their proposal to be considered for evaluation, they must be registered in MissouriBUYS. If not registered at time of proposal opening, the vendor must register in MissouriBUYS upon request by the state immediately after proposal opening.

SIGNATURE REQUIRED

VENDOR NAME	MissouriBUYS SYSTEM ID (SEE VENDOR PROFILE - MAIN INFORMATION SCREEN)
MAILING ADDRESS	
CITY, STATE, ZIP CODE	

CONTACT PERSON	EMAIL ADDRESS
PHONE NUMBER	FAX NUMBER
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

ADDENDUM #03 to RFPS30034902200777

TITLE: **MO HealthNet Managed Care Program**

CONTRACT PERIOD: **Effective Date of Contract through One Year**

Vendors are advised of the following revisions, deletions, and/or additions:

- Paragraph 2.5.18
- Paragraph 2.6.6, subparagraph a. 2), 1st bullet point
- Paragraph 2.7.16
- Paragraph 2.8.5, subparagraph i. 9), 3rd bullet point
- Paragraph 2.16.3, subparagraph g.
- Paragraph 3.7.2, subparagraphs b. and b. 1)
- Paragraph 3.9.2, subparagraph i.
- Paragraph 5.3.1, subparagraph e. 1)
- Exhibit B

Vendors may review the revisions to the MissouriBUYS electronic solicitation and the addendum documents at https://MissouriBUYS.mo.gov. You may be required to accept the electronic addendum.

ATTENTION: IF YOU HAVE ALREADY SUBMITTED A PROPOSAL RESPONSE, YOU MAY BE REQUIRED TO ACCEPT THE ADDENDUM AND RE-SUBMIT YOUR PROPOSAL TO ENSURE THE STATE OF MISSOURI SUCCESSFULLY RECEIVES YOUR PROPOSAL.

To determine if you are required to accept the addendum and need to re-submit your proposal, follow the steps below:

1) Log into MissouriBUYS.
2) Click on the **Solicitations** navigation menu.
3) Click on **View Current Solicitations** for State of Missouri.
4) Locate the Solicitation by entering the solicitation number in the Filter By Opp. No field with the **My List** or **Other Active Opportunities** tabs.
5) Click the **Submit** button.
6) If the solicitation appears on the **My List** tab, and the status of your proposal response is **"Draft"**, proceed to the "Bid Response is in Draft Status" below. If the solicitation does not appear on the **My List** tab, locate the solicitation on the **Other Active Opportunities** tab and determine if your proposal response is in **"Draft"** or **"Responded"** status. If the status is **"Draft"**, proceed to the "Bid Response is in Draft Status" steps below. If the status is **"Responded"**, proceed to the "Bid Response is in Responded Status" steps if you wish to amend your proposal response.

Proposal Response is in Draft Status:

1) Click the ellipses on the **Draft** status.
2) Click **Submit/Edit Your Response**.
3) Click the ellipses under **Addendum Actions** in the Solicitation History section of the Overview page.
4) Click **View & Accept Change Details**.
5) Review the **Addendum Details Report**.
6) Click the **Accept Addendum** button (if button appears indicating addendum is required prior to proposal submission).
7) If you clicked the Accept Addendum button in previous step, click **Yes** on the "Do you want to accept this addendum?" confirmation question to accept the addendum.

8) Click on the appropriate pages on the navigation bar to complete the required information and revise your proposal response, as applicable.
9) Click on **Review Response** from the navigation bar, and then click on **Submit** to submit your response.

Proposal Response is in Responded Status:

1) Click the ellipses on the **Responded** status.
2) Click **Retract & Edit Response**.
3) Click the **Overview** page.
4) Click the ellipses under **Addendum Actions** in the Solicitation History section of the Overview page.
5) Click **View & Accept Change Details**.
6) Review the **Addendum Details Report**.
7) Click **Close**.
8) If no changes are necessary to your proposal response, click **Close** from the **Review Response** page. If changes are necessary, proceed to Step 9.
9) If you need to update line item pricing and/or add additional documents as a result of the addendum, click the **Retract** button from the **Review Response** page.
10) A message will come up asking, "Are you sure you want to retract the Bid." Click on **Continue** to confirm.
11) Click on the appropriate pages on the navigation bar to complete the required information and revise your proposal response, as applicable.
12) Click on **Review Response** from the navigation bar, and then click on **Submit** to submit your response.

If you have not previously responded to the solicitation, follow the steps below:

1) Log into MissouriBUYS.
2) Click on the **Solicitations** navigation menu.
3) Click on **View Current Solicitations** for State of Missouri.
4) Locate the Solicitation by entering solicitation number in the Filter By Opp. No field on the **My List** tab and click the **Submit** button. If the solicitation does not appear on the **My List** tab, locate the solicitation on the **Other Active Opportunities** tab.
5) Click the **+ Add New Response** button.
6) Enter a **Quote Name** in the Quote Name box.
7) Click **OK**.
8) Click the ellipses under **Addendum Actions** in the Solicitation History section of the Overview page.
9) Click **View & Accept Change Details**.
10) Review the **Addendum Details Report**.
11) Click the **Accept Addendum** button (if button appears indicating addendum is required prior to proposal submission).
12) If you clicked the Accept Addendum button in previous step, click **Yes** on the "Do you want to accept this addendum?" confirmation question to accept the addendum.
13) Click on the appropriate pages on the navigation bar to complete the required information and revise your proposal response, as applicable.
14) Click on **Review Response** from the navigation bar, and then click on **Submit** to submit your response.

NOTE: The electronic solicitation revision may not include all of the revisions included in the addendum document(s); therefore, the vendor is advised to download, review, and accept the addendum document(s).

Please follow these steps to accept the addendum documents(s):

1) If you have not accepted the original solicitation document, go to the **Overview** page, find the section titled, **Original Solicitation Documents**, review the solicitation document(s), then click on the box under **Select**, and then click on the **Accept** button.

2) To accept the addendum document, on the **Overview** page, find the section titled **Addendum Document**, review the addendum document(s), then click on the box under **Select**, and then click on the **Accept** button.

STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING (PURCHASING)
REQUEST FOR PROPOSAL (RFP)

ADDENDUM NO.: 02 **REQ NO.: RX012200028**
SOLICITATION/OPPORTUNITY (OPP) NO.: RFPS30034902200777 **BUYER: Megan Howser**
TITLE: MO HealthNet Managed Care Program **PHONE NO.: (573) 751-1686**
ISSUE DATE: December 22, 2021 **E-MAIL: megan.howser@oa.mo.gov**

RETURN PROPOSAL NO LATER THAN: January 12, 2022 AT 2:00 PM CENTRAL TIME (END DATE)

RFP RESPONSE MUST BE SUBMITTED ELECTRONICALLY THROUGH MISSOURIBUYS. MAILED, COURIER, OR HAND-DELIVERED RFP RESPONSE WILL NOT BE ACCEPTED.

VENDORS MUST RESPOND ELECTRONICALLY THROUGH HTTPS://MISSOURIBUYS.MO.GOV

CONTRACT PERIOD: Effective Date of Contract through One Year

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

Missouri Department of Social Services
MO HealthNet Division
615 Howerton Court, PO Box 6500
Jefferson City, MO 65102-6500

The vendor 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 addendums. The vendor should, as a matter of clarity and assurance, also sign and return all previously issued RFP addendum(s) and the original RFP document. The vendor agrees that the language of the original RFP as modified by this and any previously issued RFP addendums shall govern in the event of a conflict with his/her proposal. The vendor further agrees that upon receipt of an authorized purchase order from the Division of Purchasing 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 vendor and the State of Missouri. The vendor shall understand and agree that in order for their proposal to be considered for evaluation, they must be registered in MissouriBUYS. If not registered at time of proposal opening, the vendor must register in MissouriBUYS upon request by the state immediately after proposal opening.

SIGNATURE REQUIRED

VENDOR NAME	MissouriBUYS SYSTEM ID (SEE VENDOR PROFILE - MAIN INFORMATION SCREEN)
MAILING ADDRESS	
CITY, STATE, ZIP CODE	

CONTACT PERSON	EMAIL ADDRESS
PHONE NUMBER	FAX NUMBER
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

ADDENDUM #02 to RFPS30034902200777

TITLE: **MO HealthNet Managed Care Program**

CONTRACT PERIOD: **Effective Date of Contract through One Year**

Vendors are advised of the following revisions:

1. The Return Proposal No Later Than Date has revised to January 12, 2022 in lieu of December 29, 2021.

2. The attendance sheet from the Pre-Proposal Tele-Conference has been uploaded to MissouriBUYS and can be found under the Addendum Documents.

3. Attachment 2 and Attachment 6 have been revised, have been uploaded to MissouriBUYS, and can be found under Addendum Documents for vendor download.

4. Attachment 8 has been added by Addendum 02, has been uploaded to MissouriBUYS, and can be found under Addendum Documents for vendor download.

5. The Solicitation Organization list has been revised to include Attachment 8.

6. In addition, the following paragraphs have been revised, deleted, and/or added:
   - ✓ Paragraph 1.6.1
   - ✓ Paragraph 1.7.2, subparagraph d.
   - ✓ Paragraph 1.7.2, subparagraphs e. 1) and 3)
   - ✓ Paragraph 1.7.3, subparagraph b. 3)
   - ✓ Paragraph 1.7.4, subparagraph m.
   - ✓ Paragraph 1.9.1
   - ✓ Paragraph 2.1.7, subparagraph a. 1), 4th bullet point
   - ✓ Paragraph 2.1.7, subparagraph b. 9)
   - ✓ Paragraph 2.1.7, subparagraphs d. and d. 1)
   - ✓ Paragraph 2.1.7, subparagraph f.
   - ✓ Paragraph 2.1.7, subparagraph g. 4)
   - ✓ Paragraph 2.2.1, subparagraphs a. and c.
   - ✓ Paragraph 2.2.2, subparagraphs c., j. 1), l., and s.
   - ✓ Paragraph 2.2.9
   - ✓ Paragraph 2.5.9, subparagraphs d., d. 1) 1st bullet point, 2nd bullet point, 3rd bullet point, 4th bullet point, 5th bullet point, 6th bullet point, 7th bullet point, 9th bullet point, and 10th bullet point
   - ✓ Paragraph 2.5.13, subparagraph a. 2)
   - ✓ Paragraph 2.7.23, subparagraph a.
   - ✓ Paragraph 2.7.23, subparagraphs b. 1) and 2)
   - ✓ Paragraph 2.7.24 subparagraphs a. 2), 3), and 4)
   - ✓ Paragraph 2.8.5, subparagraph i. 1) 7th bullet point, i. 9) 1st bullet point
   - ✓ Paragraph 2.8.5, subparagraph p. 4) 3rd bullet point
   - ✓ Paragraph 2.8.9
   - ✓ Paragraph 2.11.7, subparagraph c.
   - ✓ Paragraph 2.12.1, subparagraphs d. 18) and f. 4)
   - ✓ Paragraph 2.13.18, subparagraph c.
   - ✓ Paragraph 2.19.6, subparagraph a.
   - ✓ Paragraph 2.23.11, subparagraph a. 2)
   - ✓ Paragraph 2.23.12
   - ✓ Paragraph 2.23.20
   - ✓ Paragraph 2.30.4, subparagraph b. 3)
   - ✓ Paragraph 2.30.4, subparagraph e.
   - ✓ Paragraph 2.30.6, subparagraphs a. table and b. table

- ✓ Paragraph 3.4.1, subparagraph a.
- ✓ Paragraph 3.17.2, subparagraph a.
- ✓ Exhibit A
- ✓ Exhibit B
- ✓ Exhibit C
- ✓ Exhibit D
- ✓ Exhibit E
- ✓ Exhibit F
- ✓ Exhibit J
- ✓ Exhibit K
- ✓ Exhibit S

Vendors may review the revisions to the MissouriBUYS electronic solicitation and the addendum documents at https://MissouriBUYS.mo.gov. You may be required to accept the electronic addendum.

ATTENTION: IF YOU HAVE ALREADY SUBMITTED A PROPOSAL RESPONSE, YOU MAY BE REQUIRED TO ACCEPT THE ADDENDUM AND RE-SUBMIT YOUR PROPOSAL TO ENSURE THE STATE OF MISSOURI SUCCESSFULLY RECEIVES YOUR PROPOSAL.

To determine if you are required to accept the addendum and need to re-submit your proposal, follow the steps below:

1) Log into MissouriBUYS.
2) Click on the **Solicitations** navigation menu.
3) Click on **View Current Solicitations** for State of Missouri.
4) Locate the Solicitation by entering the solicitation number in the Filter By Opp. No field with the **My List** or **Other Active Opportunities** tabs.
5) Click the **Submit** button.
6) If the solicitation appears on the **My List** tab, and the status of your proposal response is **"Draft"**, proceed to the "Bid Response is in Draft Status" below. If the solicitation does not appear on the **My List** tab, locate the solicitation on the **Other Active Opportunities** tab and determine if your proposal response is in **"Draft"** or **"Responded"** status. If the status is **"Draft"**, proceed to the "Bid Response is in Draft Status" steps below. If the status is **"Responded"**, proceed to the "Bid Response is in Responded Status" steps if you wish to amend your proposal response.

Proposal Response is in Draft Status:

1) Click the ellipses on the **Draft** status.
2) Click **Submit/Edit Your Response**.
3) Click the ellipses under **Addendum Actions** in the Solicitation History section of the Overview page.
4) Click **View & Accept Change Details**.
5) Review the **Addendum Details Report**.
6) Click the **Accept Addendum** button (if button appears indicating addendum is required prior to proposal submission).
7) If you clicked the Accept Addendum button in previous step, click **Yes** on the "Do you want to accept this addendum?" confirmation question to accept the addendum.
8) Click on the appropriate pages on the navigation bar to complete the required information and revise your proposal response, as applicable.
9) Click on **Review Response** from the navigation bar, and then click on **Submit** to submit your response.

Proposal Response is in Responded Status:

1) Click the ellipses on the **Responded** status.
2) Click **Retract & Edit Response**.
3) Click the **Overview** page.
4) Click the ellipses under **Addendum Actions** in the Solicitation History section of the Overview page.
5) Click **View & Accept Change Details**.
6) Review the **Addendum Details Report**.

7) Click **Close**.
8) If no changes are necessary to your proposal response, click **Close** from the **Review Response** page. If changes are necessary, proceed to Step 9.
9) If you need to update line item pricing and/or add additional documents as a result of the addendum, click the **Retract** button from the **Review Response** page.
10) A message will come up asking, "Are you sure you want to retract the Bid." Click on **Continue** to confirm.
11) Click on the appropriate pages on the navigation bar to complete the required information and revise your proposal response, as applicable.
12) Click on **Review Response** from the navigation bar, and then click on **Submit** to submit your response.

If you have not previously responded to the solicitation, follow the steps below:

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5) Click the **+ Add New Response** button.
6) Enter a **Quote Name** in the Quote Name box.
7) Click **OK**.
8) Click the ellipses under **Addendum Actions** in the Solicitation History section of the Overview page.
9) Click **View & Accept Change Details**.
10) Review the **Addendum Details Report**.
11) Click the **Accept Addendum** button (if button appears indicating addendum is required prior to proposal submission).
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Please follow these steps to accept the addendum documents(s):

1) If you have not accepted the original solicitation document, go to the **Overview** page, find the section titled, **Original Solicitation Documents**, review the solicitation document(s), then click on the box under **Select**, and then click on the **Accept** button.

2) To accept the addendum document, on the **Overview** page, find the section titled **Addendum Document**, review the addendum document(s), then click on the box under **Select**, and then click on the **Accept** button.

STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING (PURCHASING)
REQUEST FOR PROPOSAL (RFP)

ADDENDUM NO.: 01
SOLICITATION/OPPORTUNITY (OPP) NO.: RFPS30034902200777
TITLE: MO HealthNet Managed Care Program
ISSUE DATE: November 30, 2021

REQ NO.: RX012200028
BUYER: Megan Howser
PHONE NO.: (573) 751-1686
E-MAIL: megan.howser@oa.mo.gov

Addendum 02 revised the Return Proposal No Later to Date to January 12, 2022 in lieu of December 29, 2021.
RETURN PROPOSAL NO LATER THAN: December 29, 2021 AT 2:00 PM CENTRAL TIME (END DATE)

RFP RESPONSE MUST BE SUBMITTED ELECTRONICALLY THROUGH MISSOURIBUYS. MAILED, COURIER, OR HAND-DELIVERED RFP RESPONSE WILL NOT BE ACCEPTED.

VENDORS MUST RESPOND ELECTRONICALLY THROUGH HTTPS://MISSOURIBUYS.MO.GOV

CONTRACT PERIOD: Effective Date of Contract through One Year

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

Missouri Department of Social Services
MO HealthNet Division
615 Howerton Court, PO Box 6500
Jefferson City, MO 65102-6500

The vendor 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 addendums. The vendor should, as a matter of clarity and assurance, also sign and return all previously issued RFP addendum(s) and the original RFP document. The vendor agrees that the language of the original RFP as modified by this and any previously issued RFP addendums shall govern in the event of a conflict with his/her proposal. The vendor further agrees that upon receipt of an authorized purchase order from the Division of Purchasing 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 vendor and the State of Missouri. The vendor shall understand and agree that in order for their proposal to be considered for evaluation, they must be registered in MissouriBUYS. If not registered at time of proposal opening, the vendor must register in MissouriBUYS upon request by the state immediately after proposal opening.

SIGNATURE REQUIRED

VENDOR NAME	MissouriBUYS SYSTEM ID (SEE VENDOR PROFILE - MAIN INFORMATION SCREEN)
MAILING ADDRESS	
CITY, STATE, ZIP CODE	

CONTACT PERSON	EMAIL ADDRESS
PHONE NUMBER	FAX NUMBER
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

ADDENDUM #01 to RFPS30034902200777

TITLE: **MO HealthNet Managed Care Program**

CONTRACT PERIOD: **Effective Date of Contract through One Year**

Vendors are advised of the following revisions:

1. Addendum 01 added Attachment 7 to the documents that have been uploaded to MissouriBUYS and that can be found under Addendum documents for vendor download.

2. The Solicitation Organization list has been revised to include Attachment 7.

3. Exhibit A, Pricing Pages Instructions and Information has been revised.

Vendors may review the revision(s) to the MissouriBUYS electronic solicitation and the addendum documents at https://MissouriBUYS.mo.gov. Vendors may be required to accept the electronic addendum.

ATTENTION: IF VENDORS HAVE ALREADY SUBMITTED A PROPOSAL RESPONSE, VENDORS MAY BE REQUIRED TO ACCEPT THE ADDENDUM AND RE-SUBMIT THEIR PROPOSAL TO ENSURE THE STATE OF MISSOURI SUCCESSFULLY RECEIVES THE VENDOR PROPOSAL.

To determine if a vendor is required to accept the addendum and re-submit the proposal, follow the steps below:

1) Log into MissouriBUYS.
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3) Click on **View Current Solicitations** for State of Missouri.
4) Locate the Solicitation by entering the solicitation number in the Filter By Opp. No field with the **My List** or **Other Active Opportunities** tabs.
5) Click the **Submit** button.
6) If the solicitation appears on the **My List** tab, and the status of your proposal response is **"Draft"**, proceed to the "Bid Response is in Draft Status" below. If the solicitation does not appear on the **My List** tab, locate the solicitation on the **Other Active Opportunities** tab and determine if proposal response is in **"Draft"** or **"Responded"** status. If the status is **"Draft"**, proceed to the "Bid Response is in Draft Status" steps below. If the status is **"Responded"**, proceed to the "Bid Response is in Responded Status" steps if you wish to amend your proposal response.

Bid Response is in Draft Status:

1) Click the ellipses on the **Draft** status.
2) Click **Submit/Edit Your Response**.
3) Click the ellipses under **Addendum Actions** in the Solicitation History section of the Overview page.
4) Click **View & Accept Change Details**.
5) Review the **Addendum Details Report**.
6) Click the **Accept Addendum** button (if button appears indicating addendum is required prior to proposal submission).
7) If you clicked the Accept Addendum button in previous step, click **Yes** on the "Do you want to accept this addendum?" confirmation question to accept the addendum.
8) Click on the appropriate pages on the navigation bar to complete the required information and revise your proposal response, as applicable.
9) Click on **Review Response** from the navigation bar, and then click on **Submit** to submit your proposal response.

Bid Response is in Responded Status:

1) Click the ellipses on the **Responded** status.
2) Click **Retract & Edit Response**.
3) Click the **Overview** page.
4) Click the ellipses under **Addendum Actions** in the Solicitation History section of the Overview page.
5) Click **View & Accept Change Details**.
6) Review the **Addendum Details Report**.
7) Click **Close**.
8) If no changes are necessary to your proposal response, click **Close** from the **Review Response** page. If changes are necessary, proceed to Step 9.
9) If you need to add additional documents as a result of the addendum, click the **Retract** button from the **Review Response** page.
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If a vendor has not previously responded to the solicitation, follow the steps below:

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5) Click the **+ Add New Response** button.
6) Enter a **Quote Name** in the Quote Name box.
7) Click **OK**.
8) Click the ellipses under **Addendum Actions** in the Solicitation History section of the Overview page.
9) Click **View & Accept Change Details**.
10) Review the **Addendum Details Report**.
11) Click the **Accept Addendum** button (if button appears indicating addendum is required prior to proposal submission).
12) If vendor clicked the Accept Addendum button in previous step, click **Yes** on the "Do you want to accept this addendum?" confirmation question to accept the addendum.
13) Click on the appropriate pages on the navigation bar to complete the required information and revise the proposal response, as applicable.
14) Click on **Review Response** from the navigation bar, and then click on **Submit** to submit the proposal response.

NOTE: The electronic solicitation revision may not include all of the revisions included in the addendum document(s); therefore, the vendor is advised to download, review, and accept the addendum document(s).

Please follow these steps to accept the addendum documents(s):

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STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING (PURCHASING)
REQUEST FOR PROPOSAL (RFP)

SOLICITATION/OPPORTUNITY (OPP) NO.: RFPS30034902200777
TITLE: MO HealthNet Managed Care Program
ISSUE DATE: November 19, 2021

REQ NO.: RX012200028
BUYER: Megan Howser
PHONE NO.: (573) 751-1686
E-MAIL: megan.howser@oa.mo.gov

Addendum 02 revised the Return Proposal No Later to Date to January 12, 2022 in lieu of December 29, 2021.
RETURN PROPOSAL NO LATER THAN: December 29, 2021 AT 2:00 PM CENTRAL TIME (END DATE)

RFP RESPONSE MUST BE SUBMITTED ELECTRONICALLY THROUGH MISSOURIBUYS. MAILED, COURIER, OR HAND-DELIVERED RFP RESPONSE WILL NOT BE ACCEPTED.

VENDORS MUST RESPOND ELECTRONICALLY THROUGH HTTPS://MISSOURIBUYS.MO.GOV

CONTRACT PERIOD: Effective Date of Contract through One Year

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

Missouri Department of Social Services
MO HealthNet Division
615 Howerton Court, PO Box 6500
Jefferson City, MO 65102-6500

The vendor 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 06/27/19). The vendor further agrees that the language of this RFP shall govern in the event of a conflict with his/her proposal. The vendor further agrees that upon receipt of an authorized purchase order from the Division of Purchasing 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 vendor and the State of Missouri. The vendor shall understand and agree that in order for their proposal to be considered for evaluation, they must be registered in MissouriBUYS. If not registered at time of proposal opening, the vendor must register in MissouriBUYS upon request by the state immediately after proposal opening.

SIGNATURE REQUIRED

VENDOR NAME	MissouriBUYS SYSTEM ID (SEE VENDOR PROFILE - MAIN INFORMATION SCREEN)
MAILING ADDRESS	
CITY, STATE, ZIP CODE	

CONTACT PERSON	EMAIL ADDRESS
PHONE NUMBER	FAX NUMBER
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

Solicitation Organization:

This document is divided into the following parts:

Section 1: Introduction and General Information
Section 2: Scope of Work – General Plan
Section 3: Scope of Work – Specialty Plan
Section 4: Contractual Requirements
Section 5: Proposal Submission Information and Requirements
Exhibit A: Pricing Pages Instructions
Exhibit B: Organizational Experience – General Plan
Exhibit C: Methodology and Approach – General Plan
Exhibit D: Quality – General Plan
Exhibit E: Access to Care and Care Management – General Plan
Exhibit F: Medicaid Reform and Transformation – General Plan
Exhibit G: Executive Summary – General Plan
Exhibit H: Organizational Experience – Specialty Plan
Exhibit I: Methodology and Approach – Specialty Plan
Exhibit J: Quality – Specialty Plan
Exhibit K: Access to Care – Specialty Plan
Exhibit L: Care Management – Specialty Plan
Exhibit M: Medicaid Reform and Transformation – Specialty Plan
Exhibit N: Participation Commitment
Exhibit O: Documentation of Intent to Participate
Exhibit P: Business Entity Certification, Enrollment Documentation, and Affidavit of Work Authorization
Exhibit Q: Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tiered Covered Transactions
Exhibit R: Anti-Discrimination Against Israel Act Certification
Exhibit S: Miscellaneous Information
Terms and Conditions

Attachment 1 – MO HealthNet Managed Care Eligibility Groups
Attachment 2 – Actuarial Memorandum
Attachment 3 – Pricing Pages
Attachment 4 – Technical Proposal Evaluation – General Plan
Attachment 5 – Technical Proposal Evaluation – Specialty Plan
Attachment 6 – Federally Qualified Health Clinics, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Family Planning, and STD Providers

Addendum 01 added the following Attachment.

Attachment 7 – Actuarial Memorandum Appendices

Addendum 02 added the following Attachment.

Attachment 8 – Mercer Managed Care Rate Development SFY 2023

Attachments - The vendor is advised that attachments to the documents referenced above provide additional requirements, information, and/or instruction. The attachments are separate downloadable documents located on the same page where the solicitation documents are downloadable from the Division of Purchasing's MissouriBUYS website at: https://missouribuys.mo.gov/. It shall be the sole responsibility of the vendor to obtain the attachments. The vendor shall not be relieved of any responsibility for performance under a subsequently awarded contract due to the failure of the vendor to obtain attachments.

1. INTRODUCTION AND GENERAL INFORMATION

This section of the solicitation includes a brief introduction and background information about the intended acquisition for which the requirements herein are written.

1.1 Introduction:

1.1.1 This document constitutes a request for competitive, sealed proposals for providers of the "MO HealthNet (MHD) Managed Care Program" for all regions in the State of Missouri. The MHD Managed Care Program contains a General Plan, hereinafter referred to as the "General Plan", and a Specialty Plan, hereinafter referred to as the "Specialty Plan". Where specifically noted herein, certain provisions, including the capitated rate structure and the enrollment process for the General Plan, will be implemented on a regional basis. All proposals shall cover all MHD Managed Care Program Regions encompassing all of the State of Missouri as follows:

a. Central Region – Adair, Andrew, Atchison, Audrain, Benton, Bollinger, Boone, Buchanan, Butler, Caldwell, Callaway, Camden, Cape Girardeau, Carroll, Carter, Chariton, Clark, Clinton, Cole, Cooper, Crawford, Daviess, DeKalb, Dent, Dunklin, Gasconade, Gentry, Grundy, Harrison, Holt, Howard, Iron, Knox, Laclede, Lewis, Linn, Livingston, Macon, Maries, Marion, Mercer, Miller, Mississippi, Moniteau, Monroe, Montgomery, Morgan, New Madrid, Nodaway, Osage, Pemiscot, Pettis, Phelps, Pulaski, Putnam, Ralls, Randolph, Reynolds, Ripley, Saline, Schuyler, Scotland, Scott, Shelby, Stoddard, Sullivan, Wayne, and Worth 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. Southwestern Region – Barry, Barton, Christian, Dade, Dallas, Douglas, Greene, Hickory, Howell, Jasper, Lawrence, McDonald, Newton, Oregon, Ozark, Shannon, Stone, Taney, Texas, Webster and Wright counties.

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

1.2 RFP Questions:

1.2.1 Questions and issues relating to the RFP must be directed to the buyer. It is preferred that questions be e-mailed to the buyer at megan.howser@oa.mo.gov.

1.2.2 It is the vendor's responsibility to ask questions, request changes or clarifications, or otherwise advise the Division of Purchasing if the vendor believes that any language, specifications, or requirements are: (1) ambiguous, (2) contradictory or arbitrary, (3) violate any state or federal law or regulation, (4) restrict or limit the requirements to a single source, or (5) restrict or limit the vendor's ability to submit a proposal.

a. Vendors and their agents (including subcontractors, employees, consultants, or anyone else acting on their behalf) must direct all of their questions or comments regarding the RFP, the evaluation, etc., to the buyer of record indicated on the first page of this RFP. Vendors and their agents may not contact any other state employee regarding any of these matters during the solicitation and evaluation process. Inappropriate contacts are grounds for suspension and/or exclusion from specific procurements. Vendors and their agents who have questions regarding this matter should contact the buyer of record.

1) The vendor may contact the Office of Equal Opportunity (OEO) regarding Minority Business Enterprise/Women Business Enterprise (MBE/WBE) certification or subcontracting.

1.2.3 All questions and issues should be submitted by no later than ten calendar days prior to the proposal due date. If not received prior to ten days before the proposal due date, the Division of Purchasing may not be able to fully research and consider the respective questions or issues.

1.2.4 Upon the Division of Purchasing's consideration of questions and issues, if the Division of Purchasing determines that changes are necessary, the resulting changes will be included in a subsequently issued RFP addendum(s); absence of such response indicates that the questions and issues were considered but deemed unnecessary for a RFP addendum. All vendors will be advised of any change to the RFP's language, specifications, or requirements by a formal addendum to the RFP. There will be no posted written records of the questions/communications (i.e., formal question/answer document).

NOTE – The only official position of the State of Missouri shall be that which is contained in the RFP and any addendums thereto.

1.3 Pre-Proposal Tele-Conference:

1.3.1 A pre-proposal tele-conference regarding this RFP will be held on December 6, 2021 at 10:00 a.m. Central Standard Time.

1.3.2 The vendor should have a copy of the RFP for the pre-proposal tele-conference since the RFP will be used as the agenda for the pre-proposal tele-conference.

1.3.3 All potential vendors are encouraged to participate in the pre-proposal tele-conference, as it will be used as the forum for questions, communications, and discussions regarding the RFP. Vendors should become familiar with the RFP and should develop all questions prior to the pre-proposal tele-conference in order to ask questions and otherwise participate in the public communications regarding the RFP.

a. The vendor may submit written communications or questions regarding the RFP, which reference the RFP paragraph numbers, to the buyer identified herein. Such communication(s) will provide the State of Missouri with insight into areas of the RFP which may be brought up for discussion during the pre-proposal tele-conference and which may require clarification.

b. During the pre-proposal tele-conference, it shall be the sole responsibility of vendors to orally address all issues previously presented to the buyer by vendors, including any questions regarding the RFP or areas of the RFP requiring clarification.

c. Any changes needed to the RFP as a result of discussions from the pre-proposal tele-conference will be accomplished as an addendum to the RFP. Neither formal minutes of the conference nor written records of the questions/communications will be maintained.

1.3.4 Pre-Proposal Tele-Conference Special Accommodations - Vendors are strongly encouraged to advise the Division of Purchasing within five business days of the scheduled pre-proposal tele-conference of any special accommodations needed for disabled personnel who will be participating in the pre-proposal tele-conference so that any necessary accommodations can be made.

1.3.5 Vendors must contact the buyer from the Division of Purchasing as indicated below to obtain dial-in instructions. Vendors will be provided with a telephone number to dial, in order to listen and participate in the pre-proposal tele-conference. Vendors shall refrain from contacting the state agency.

a. Contact the buyer by phone at (573-751-1686) or by email at megan.howser@oa.mo.gov.

1.4 Available Documentation:

1.4.1 The vendor is advised that important documents, instructions, schedules, and templates exist in addition to this document. Such information is located and periodically updated on the state agency website at https://dss.mo.gov/business-processes/managed-care-2023/.

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

1.5 Description of MO HealthNet Managed Care Programs:

1.5.1 The State of Missouri, Department of Social Services (DSS), operates the MHD Managed Care Program statewide, in all regions of the State of Missouri. The goals of the Managed Care Program are to improve access to needed services and the quality of health care services for the Managed Care and state aid eligible populations, while controlling the Managed Care Program's rate of cost increase.

a. The MHD intends to achieve these goals by enrolling Managed Care Program 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 (RFP).

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

1.5.3 DSS/MHD has identified nine guiding principles for the Managed Care 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. Care 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. Evidence-based guidelines for improved quality of care and use of resources.

h. Encouragement of 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, Value-Based Purchasing Strategies, and requirements for increased accountability and transparency.

j. Ensuring that the needs of vulnerable Missourians are addressed in a financially sustainable manner.

1.6 Program Management and Oversight:

Addendum 02 revised the paragraph below.

1.6.1 In the State of Missouri, DSS/MHD 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) (CHIP) programs. The Family Support Division (F***S***D) is designated with the administration

and determination of eligibility for the two programs. In addition to DSS/MHD oversight, CMS also monitors DSS/MHD Managed Care Program activities through its regional office in Kansas City, Missouri and its Center for Medicaid and CHIP Services and the Survey Operations Group, and the Quality, Safety, and Oversight Group in Baltimore, Maryland.

1.6.2 An amendment to the Missouri Constitution passed in August 2020 that requires the DSS, MHD to modify its Medicaid and CHIP programs to include low-income adults ages 19-64. Potential enrollees could be eligible for benefits effective July 1, 2021 and will be enrolled in Managed Care, effective October 1, 2021.

1.7 MO HealthNet Managed Care Program Eligibility Groups:

1.7.1 For purposes of this RFP, the MHD Managed Care Program population consists of different eligibility groups that 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, age, or pregnancy 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 Eligibility Groups and as located on the state agency website.

1.7.2 **Covered Under the MHD Managed Care Program General Plan** – The following individuals are covered and receive their services under the MHD Managed Care General Plan. Those eligible are defined by their MHD Managed Care Program Medicaid Eligibility (ME) Code as specified in Attachment 1, MO HealthNet Managed Care Eligibility Groups and as located on the state agency website.

a. Parents, Caretakers, and Children – Individuals covered under the MHD Managed Care Program within this group are as follows:

1) Parents, Caretakers, and Children eligible under the MHD Managed Care Program for Families, and the MHD Managed Care Program for Transitional Assistance;

2) Children eligible under the MHD Managed Care Program for Poverty Level Children;

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

b. Pregnant Women;

1) Individuals eligible under the MHD Managed Care Program for Pregnant Women are pregnant and women 60 calendar days post-partum; and

2) Low-income pregnant women and their unborn children with household income up to 300% of the FPL who are not eligible under the MHD Managed Care Program for Pregnant Women are eligible under the Show-Me Healthy Babies Program.

c. 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.

Addendum 02 revised the subparagraph below.

d. Adult Expansion Group (AEG) – Those eligible under this group are adult***s*** age 19-64 with income up to 138% of FPL.

e. MHD Managed Care Program eligibles in the above-referenced eligibility groups may voluntarily disenroll from the Managed Care Program or choose not to enroll in the Managed Care Program if they:

Addendum 02 revised the subparagraph below.

1) Are eligible for Supplemental Security Income (SSI) under Title XVI of the A***ct***;
2) Are described in Section 501(a)(1)(D) of the Act; or

Addendum 02 revised the subparagraph below.

3) Are described in Section 1902**-**(e)(3) of the Act.

1.7.3 **Covered Under the MHD Managed Care Program Specialty Plan** – The following individuals are covered and receive their services under the MHD Managed Care Program Specialty Plan. Those that are eligible are defined by their MHD Managed Care Program Medical Eligibility Code as specified in Attachment 1, MO HealthNet Managed Care Eligibility Groups and as located on the state agency website.

a. Children in the care and custody of the state and receiving adoption subsidy assistance – All children in the care and custody of DSS, all children receiving adoption subsidy assistance, and all children receiving non-medical assistance (i.e. living assistance) that are in the legal custody of DSS.

1) Persons under 26 years of age, who were in foster care on their 18th birthday and were covered by the MHD Managed Care Program, and who meet other eligibility criteria, are eligible under this category of assistance.

2) Persons under 26 years of age, who were in foster care on their 18th birthday and were covered by Medicaid from another state, but are not eligible for Medicaid coverage under another mandatory coverage group, and who meet other eligibility criteria, are eligible under this category of assistance.

b. MHD Managed Care Program eligibles in the above-referenced eligibility groups may voluntarily disenroll from the Managed Care Program or choose to not enroll in the Managed Care Program if they:

1) Are eligible for Supplemental Security Income (SSI) under Title XVI of the Act;
2) Are describe on Section 501(a)(1)(D) of the Act; or

Addendum 02 revised the subparagraph below.

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

1.7.4 **Not Covered Under the MHD Managed Care Program** – The following individuals are not covered under the MHD Managed Care Program and receive their services through the MHD 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 (MHD Spenddown and Non-Spenddown), 14 (Nursing Care-OAA), and 01 (Old Age Assistance-OAA);

b. Individuals 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. Youth eligible under ME Codes 30 (Children placed in foster homes by Juvenile Court), 64 (Juvenile Court Group Home-HIE), 69 (Juvenile Court-HIF), and 70 (Children in Juvenile Court Poverty);

e. Pregnant women eligible under ME Code 58, 59, and 94, the Presumptive Eligibility Program for ambulatory prenatal care only;

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

g. AIDS Waiver participants (individuals 21 years of age and over);

h. Any individuals who is eligible and receiving either or both Medicare Part A and Part B, or Part C benefits;

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

j. Individuals Eligible under ME Code 55 (Qualified Medicare Beneficiary-QMB);

k. Children eligible under ME Code 65, placed in residential care by their parents, if eligible for the MHD Managed Care Program on the date of placement;

l. Uninsured women losing their MHD Managed Care Program eligibility 60 calendar days after the birth of their child would be eligible under ME code 80 for women's health services for one calendar year plus 60 calendar days, regardless of income level;

Addendum 02 deleted a word from the subparagraph below.

m. Women eligible for Women's Health Services, 1115 Waiver, and ME Code 89. These are uninsured women who are at least 18 to 55 years of age, with a net family income below 185% of the 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.

n. Individuals with ME Code 81 (Temporary Assignment Category);

o. Individuals eligible under ME Code 82 (MoRx);

p. Women eligible under ME Codes 83 and 84 (Breast and Cervical Cancer Treatment);

q. Individuals eligible under ME Code 87 (Presumptive Eligibility for Children); and

r. Individuals eligible under ME Code 88 (Voluntary Placement).

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

1.8 Current Contract and Additional Relevant Information:

1.8.1 Current contracts exist for the services being obtained via this RFP. Copies of the contracts may be viewed and printed from the Division of Purchasing's Awarded Bid & Contract Document Search System located on the Internet at: http://oa.mo.gov/purchasing/bidding-contracts/awarded-bid-contract-document-search. 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's Awarded Bid & Contract Document Search System. Please reference the solicitation number RFPS30034901600685 or the contract numbers CS160685001, CS160685002, and CS160685003 when searching for these documents.

a. State expenditures – The Missouri Accountability Portal (MAP) located on the Internet at: http://mapyourtaxes.mo.gov/MAP/Expenditures/ provides financial data related to the purchase of the services under the contract. Be sure to read the information provided in the links to "Site Information"

and "Disclaimer". Then search by the contract number shown above when searching for the financial information.

1.8.2 A listing of DSS/MHD Acronyms is located on the state agency website.

1.9 Organizational Definitions:

Addendum 02 deleted a repetitive number from the paragraph below.

1.9.1 For purposes of this document, a "managing employee", as defined in 42 CFR 455.101, shall be 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.

1.9.2 For purposes of this document, a "person with an ownership or control interest" shall mean a person or corporation that (1) has an ownership interest totaling 5% or more of the vendor's organization; (2) has an indirect ownership interest equal to 5% or more of the vendor's organization; (3) has a combination of direct and indirect ownership interests equal to 5% or more in the vendor's organization; (4) owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the vendor's organization or by its property or assets, if that interest is equal to or exceeds 5% of the total property and assets of the vendor's organization; (5) is an officer or director of the vendor's organization (if it is organized as a corporation); or (6) is a partner in the vendor's organization (if it is organized as a partnership).

a. The percentage of direct ownership or control is calculated by multiplying the percent of interest which a person owns by the percent of the vendor's assets used to secure the obligation (e.g., if a person owns 10% of a note secured by 60% of the vendor's assets, the person owns 6% of the vendor).

b. The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization (e.g., if a person owns 10% of the stock in a corporation which owns 80% of the stock of the vendor's organization, the person owns 8% of the vendor's organization).

1.10 Accuracy of Background Information:

1.10.1 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 background information provided herein reflects all relationships or existing conditions related to this Request for Proposal.

2. MANAGED CARE GENERAL PLAN 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 (herein after referred to as the state agency), located in the State of Missouri, and 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 state agency 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 federal or state law. Any federal or state law 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 issue 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 county listed herein, the health plan shall:

a. Have and maintain a certificate of authority from the Department of Commerce and Insurance (hereinafter referred to as DCI) to establish and operate an health maintenance organization (hereinafter referred to as an HMO) in all the counties specified herein by the date of contract award or by no later than February 1, 2022, whichever date comes later, so that the state agency may proceed with open enrollment with only health plans that are appropriately licensed. In the event the health plan fails to achieve appropriate licensure by the date of contract award or by February 1, 2022, whichever comes later, 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. The state agency shall conduct an on-site readiness review of all health plans in order to document the status of the health plans with respect to meeting the requirements herein. 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.

1) The readiness review shall also include a review of targeted requirements outlined in the contract including the health plan's provider network, the health plan's care management and disease management program, and any other requirements of interest identified by the state agency. The requirements covered within the readiness review shall be determined at the state agency's discretion and shall be communicated accordingly with the health plan prior to the onsite review. The health plan shall submit all necessary requested documentation and complete a self-reporting tool to be submitted as requested by the state agency. The health plan is subject to a desk audit validation of the submitted documentation performed by the state agency. In addition to the readiness review, the state agency reserves the right to review all items reviewed during the readiness review on an annual basis. Any tools used by the state agency in the readiness review are subject to review and modification 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 and periodically updated on the state agency website. The health plan shall access the Policy Submission Form, also located and periodically updated on the state

agency website, to submit all modifications, additions, or deletions to such policies and procedures to the state agency at least 30 calendar 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 upon request.

2.1.5 The health plan(s) shall provide services to individuals determined eligible by the state agency for the Managed Care Program on a statewide basis in all Missouri counties, in the following four designated regions:

a. Central Region:
1) Adair County:
2) Andrew County;
3) Atchison County;
4) Audrain County;
5) Benton County;
6) Bollinger County;
7) Boone County;
8) Buchanan County;
9) Butler County;
10) Caldwell County;
11) Callaway County;
12) Camden County;
13) Cape Girardeau County;
14) Carrol County;
15) Carter County;
16) Chariton County;
17) Clark County;
18) Clinton County;
19) Cole County;
20) Cooper County;
21) Crawford County;
22) Daviess County;
23) DeKalb County;
24) Dent County;
25) Dunklin County;
26) Gasconade County;
27) Gentry County;
28) Grundy County;
29) Harrison County;
30) Holt County;
31) Howard County;
32) Iron County;
33) Knox County;
34) Laclede County;
35) Lewis County;
36) Linn County;
37) Livingston County;
38) Macon County;
39) Maries County;
40) Marion County;
41) Mercer County;
42) Miller County;
43) Mississippi County;

44) Moniteau County;
45) Monroe County;
46) Montgomery County;
47) Morgan County;
48) New Madrid County;
49) Nodaway County;
50) Osage County;
51) Pemiscot County;
52) Pettis County;
53) Phelps County;
54) Pulaski County;
55) Putnam County;
56) Ralls County;
57) Randolph County;
58) Reynolds County;
59) Ripley County;
60) Saline County;
61) Schuyler County;
62) Scotland County;
63) Scott County;
64) Shelby County;
65) Stoddard County;
66) Sullivan County;
67) Wayne County; and
68) Worth County.

b. 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; and
13) St. Louis City.

c. Southwestern Region:
1) Barry County;
2) Barton County;
3) Christian County;
4) Dade County;
5) Dallas County;
6) Douglas County;
7) Greene County;
8) Hickory County;
9) Howell County;
10) Jasper County;
11) Lawrence County;
12) McDonald County;
13) Newton County;

14) Oregon County;
15) Ozark County;
16) Shannon County;
17) Stone County;
18) Taney County;
19) Texas County;
20) Webster County; and
21) Wright County.

d. 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; and
13) Vernon County.

2.1.6 The state agency will notify the health plan, via a contract amendment, if:

a. There are any significant changes in services, benefits, geographic areas, or payments, or;
b. The state agency requires enrollment of a new population in the health plan.

2.1.7 **Medicaid Reform and Transformation** – The health plan shall provide programs involving: personal responsibility, promoting efficiency through state provider incentives, the Local Community Care Coordination Program and Value-Based Purchasing Strategies designed to engage members, providers, and the health plan 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 preventative care in appropriate settings;

- To promote the adoption of healthier personal habits including, at a minimum, 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

Addendum 02 added a word to the subparagraph below.

- 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 and demonstrate improved health outcomes for members;
- 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 health plan shall understand and agree that the member incentive program submitted in the health plan'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 exempt 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. The health plan shall submit the member incentive proposal to the state agency for review at least 30 calendar days before the anticipated start date for the incentive program. Please see Member Incentive Template located on the state agency website for the form that must be submitted by health plans.

- The health plan shall develop educational and outreach materials for members, parents/guardians, and providers that educates about how the member incentive programs will be administered and provide information about any administrative requirements (e.g. prior authorization requirements, etc.).
- The outreach or education materials related to the proposed member incentives are subject to a compliance audit at the discretion of the state agency. 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 the marketing activities as incentives to join a particular health plan.

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:

- 15% of eligible members shall participate in the member incentive program. The health plan shall maintain documentation demonstrating compliance with this requirement. Such documentation is subject to audit.

5) Member incentive gifts related to the delivery of preventative care services as defined by the US Preventive Care Taskforce shall be limited to a value of $30.00 or less per eligible member, per month, per incentive.

6) Member incentive gifts not related to preventive care services as defined by the US Preventative Services Taskforce shall be limited to a value of $15.00 each or an aggregate annual value of $75.00.

7) The health plan shall regularly monitor their member incentive program to ensure that the member incentive 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 goals submitted to and approved by the state agency. At a minimum, monitoring activities may include audits and secret shopper activities conducted by the state agency. Member incentive programs that do not show progress must be revised annually or be discontinued.

8) Annually, the health plan shall report the status and state fiscal year results of the member incentive programs to the state agency.

b. State Provider Incentive Programs:

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;
   - Promote delivery of trauma informed care;
   - Decrease inappropriate utilization of services; and
   - 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.

3) The health plan shall agree that the state provider incentive program submitted in the health plan'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 proposal 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. Please see State Provider Incentive Program Template located on the state agency website for the template that must be used by health plans to submit their plan.

   - The health plan must ensure 10% of the defined providers participate in the provider incentive program. The health plan shall maintain documentation demonstrating compliance with this requirement. The documentation is subject to audit.

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

   - Effective date of the state provider incentive program;
   - Type of state provider incentive program;
   - Percent of withhold or bonus applied, if applicable;
   - If rendering provider or provider group is at substantial financial risk, proof that the rendering provider or provider group has adequate stop-loss coverage;
   - Amount and type of stop-loss protection, if applicable;
   - Patient panel size;
   - If patient panel is pooled, a description of the approved method;
   - 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 program.

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, at a minimum, audits and secret shopper activities conducted by the state agency.

6) The health plan shall submit an annual disclosure plan to the state agency indicating whether there have been changes to the health plan's state provider incentive program plan. If no changes

have been made to the state provider incentive program plan, the health plan shall submit a statement certifying no changes were made. The disclosure plan or statement certifying no changes may be submitted in the health plan's chosen format.

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 business days of any change to the health plan's or the subcontractors' state provider incentive program plan.

Addendum 02 added a word to the subparagraph below.

9) The health plan shall ensure that no financial or non-financial incentives offered directly or indirectly to a provider or provider group ***to*** induce the 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 438.3(i). The health plan shall require all subcontractors, including any health care services subcontractors, to comply with all physician incentive plan regulations. The physician incentive plan regulations do not apply outside the scope of physician incentive plans for healthcare providers providing services to Medicare or state agency 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 or reduce medically necessary services to a specific member.

- A physician group is at "substantial" financial risk if more than 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 (hereinafter referred to as MCO), intermediate entity, physician, or physician group may reinsure the risk through a reinsurance carrier. Stop-loss protection must cover at least 99% of the costs of referral amounts that exceed 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 following information shall be included in the health plan's physician incentive plan:

  - ✓ Effective date of the physician incentive plan;

  - ✓ Type of incentive arrangement;

  - ✓ Amount and type of stop-loss protection;

- ✓ Patient panel size;
- ✓ If patient panel is pooled, a description of the pooling method;
- ✓ 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 physician incentive plan.

- The health plan shall submit an annual disclosure statement to the state agency indicating whether there have been changes to the health plan's physician incentive plan. If no changes were made to the physician incentive plan, the health plan shall submit a statement certifying that no changes were made. The disclosure plan or statement certifying no changes may be submitted in the health plan's chosen format.
- 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 federal regulation, the health plan shall disclose to 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 business days of any change to the health plan or the contractors' physician incentive plans.

c. Local Community Care Coordination Program (hereinafter referred to as LCCCP):

1) The health plan shall develop a LCCCP to be implemented by no later than July 1, 2022. Such program may use any delivery model that focuses on providing care 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 (hereinafter referred to as ACOs), patient-centered medical homes (hereinafter referred to as PCMHs), primary care management (hereinafter referred to as PCCM), sub capitated entities, a combination thereof where a portion of reimbursement is performance based such as pay-for-performance programs or at financial risk for certain services or populations (sub capitation). Performance based reimbursement may take on many forms such as incentive or penalty programs, withhold or risk corridor arrangements, and episode payments or sub capitated risk arrangements. Health plans are encouraged to align performance based reimbursement with other programs and metrics such as the state agency's health plan performance withhold program, the state agency's Quality Strategy, Medicare outcome metrics used in other lines of business, Healthcare Effectiveness Data and Information Set (hereinafter referred to as HEDIS) metrics beyond those in the performance withhold program and avoidable admissions and emergency room visits aligned with managed care efficiencies. These models or other similar models must be consistent with the principles and requirements listed below. Providers within these applicable models may include, at a minimum, primary care physicians/specialties/groups, MCHCs, Federally Qualified Health Centers (hereinafter referred to as FQHCs), behavioral health providers/groups, or other provider types or groups that coordinate and manage the care of members. The health plan shall also describe its own internal care 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 to be approved and implemented as soon as feasible, but by no later than July 1, 2022.

2) Individuals enrolled in state-operated health homes shall not be included in a LCCCP. Individuals enrolled in a state-approved LCCCP must be provided all care management services required in a contract(s) awarded in response to this RFP.

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 or certification.

5) All LCCCPs shall incorporate the following principles:

- Every member has a selected Primary Care Provider (hereinafter referred to as a PCP);
- Care is provided by a physician-directed team that collectively cares for the member;
- Care is coordinated and integrated across all aspects of health care;
- Care is informed by continuous quality improvement strategies and aligned with the state agency's Quality Strategy;
- Member Care Management Services shall include, at a minimum, the following:
  - ✓ Comprehensive care management applying clinical knowledge to the member's condition;
  - ✓ Care coordination;
  - ✓ Health promotion services;
  - ✓ Comprehensive transitional care;
  - ✓ Individual and family support activities;
  - ✓ Disease management; and
  - ✓ Referrals to community and social supports performed at the local level by the LCCCP.
- Care includes recognition of and referral to necessary community and social support options.

6) The health plan shall ensure that each LCCCP shall do the following:

- Provide patient-centered care:
- Practice evidence-based medicine and clinical decision supports;
- Participate in continuous quality improvement and performance measurement;
- Coordinate care between all healthcare providers utilized by the member;
- Engage all members and/or family members to actively participate in decision-making and provide feedback on their health and care;
- Use health information technology to support care delivery and efficiency improvement;
- Provide for enhanced access, including at a minimum, extended office hours outside of 8:00 a.m. to 5:00 p.m. Central Standard Time (CST), open scheduling, and alternative communication models such as web-based or telephone options; and

- Ensure members enrolled in a LCCCP are not eligible for the state's health home program and the health plan's care management services.

7) It is anticipated that the development and implementation of all LCCCPs shall be budget neutral throughout the duration of the contract.

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

9) 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, at a minimum, the following:

     ✓ 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 a substance use disorder, 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;

   - Focused care on prevention, chronic care management, reduced emergency room visits and unnecessary hospitalizations, and improved 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 plan claims/encounter data, and health plan authorization data, as directed by the state agency.

10) The health plan should contract with ACOs in order to fulfill the requirements of the LCCCP program. A qualifying ACO could be a Medicare ACO or could be an entity providing a comprehensive array of medical services where a portion of reimbursement is performance based such as a pay-for-performance programs or financial risk for certain services or populations (sub capitation). Performance based reimbursement may take on many forms incentive or penalty programs, withhold or risk corridor arrangements, episode payments or sub capitated risk arrangements. Health plans should align performance based reimbursement with other programs and metrics such as the MHD health plan performance withhold programs, the state agency Quality Strategy, Medicare outcome metrics used in other lines of business, HEDIS metrics beyond those in the performance withhold program, and avoidable admissions and emergency room visits aligned with managed care efficiencies. The state agency will monitor the health plan's activity with any identified ACO during the contract period to ensure movement in the process.

11) The LCCCP shall be a subcontractor of the health plan. The health plan shall ensure that all subcontractors meet the requirements outlined in the subcontractors section of the contract.

Addendum 02 added language to the subparagraph below.

d. Value-Based Models and Purchasing Strategies – The health plan shall implement innovative provider payment or innovative delivery system design strategies, or both that incorporate performance and quality initiatives in service delivery models, referred to generally herein as Value-Based Models and Purchasing Strategies. Innovative programs may impact the delivery system, but may not require innovative provider payment. The state is interested in both, as long as the strategies support the goals and objectives of the Managed Care Program. The state seeks to ensure appropriate access to care, cost effective delivery of that care, and a focus on prevention, all while achieving a superior member experience. ***Innovative provider payment strategies that move beyond the fee-for-service payment continuum such as provider incentives, risk sharing arrangements, episode payments, etc. may be considered for Value-Based Models or Purchasing strategies, as long as all requirements specified herein are met, including reporting requirements.***

Addendum 02 added a word to the subparagraph below.

1) The health ***plan*** shall have flexibility in designing Value-Based Models and Purchasing Strategies. The health plan should develop Value-Based Models and Purchasing Strategies that coordinate across state and local agencies, community based organizations, and that coordinate across health plans to leverage data and better manage and coordinate health care and social determinants of health to deliver cost effective, high quality care. Health plans may build off and include strategies, programs, and activities leveraging existing work within LCCCPs.

2) Health plan proposals in response to the RFP may include Value-Based Models and Purchasing Strategies that are more successful for members, providers, and the state if implemented program-wide. Such models and strategies may also include collaboration and coordination between other contracted health plans to achieve program outcomes and member satisfaction.

   ✓ The health plan shall understand and agree that award of a contract does not constitute final approval of a health plan's Value-Based Models and Purchasing Strategies.

3) The state agency reserves the right to modify or revise the proposed Value-Based Models and Purchasing Strategies, metrics, and reporting requirements specified herein.

e. Reporting Requirements for Value-Based Models and Purchasing Strategies:

1) Metrics, outcomes, and other measures and reports should be readily available to providers, the health plan, and the state agency to document the effectiveness and outcomes of the Value-Based Models and Purchasing Strategies implemented under the contract, and should not be administratively burdensome.

2) Metrics, outcomes, and other measures and reports, including any standardized measures and reports shall be primarily based upon nationally accepted measure sets (for example - HEDIS and National Outcome Measures [NOMS]), and not be self-defined in nature. This is intended to align health and other measures in the state with national standards, to minimize the impact of reporting on the provider, and to allow for common data across the Managed Care Program.

3) The state agency will review proposed metrics and reports included in proposed Value-Based Models and Purchasing Strategies and may select some or all of those metrics and reports, as well as potentially include additional metrics and reports as part of the final reporting process.

Addendum 02 deleted a word from the subparagraph below.

f. Accountability and Transparency – The health plan shall implement internal controls, policies, and procedures to prevent, 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 and Program Integrity Policies, Operational Data Reporting, Encounter Data and Transactions, Member Grievance System, and Provider Complaints and Appeals sections of the contract.

g. The health plan shall participate in the Show Me ECHO project that focuses on the health care needs of Managed Care Program members and aligns with the state's health priorities.

1) The health plan shall collaborate with the state to develop the focus of the project, create evidence-based goals and expected outcomes, and develop metrics to measure health outcomes and anticipated reduced health care costs. This may include activities such as attending meetings and engaging with existing projects.

2) The health plan shall participate in Show Me ECHO projects that address the management of high-risk obstetrics cases, the reduction in the occurrence of neonatal abstinence syndrome, the management of opioid use disorder and the management of chronic pain.

3) The health plan shall assist the Missouri Telehealth Network and the state agency in evaluating outcome measures for participants in the Show Me ECHO program.

Addendum 02 revised the subparagraph below.

4) The health plan shall provide data to the Missouri Telehealth Network and the state agency for evaluating outcomes for participants in Show ***M***e ECHO projects.

5) The health plan shall work with the Missouri Telehealth Network to promote Show Me ECHO to the health care providers in Missouri, focusing on health care providers in the health plan's contracted networks.

2.2 Health Plan Administration Requirements:

2.2.1 Within the past five years, the health plan should have experience in the following areas:

Addendum 02 revised the subparagraph below.

a. ***Publicly*** funded Managed Care contracts for Medicaid, CHIP, and/or other low-income individuals;
b. Managed Care contracts for populations other than Medicaid, CHIP, and/or other low-income individuals; and

Addendum 02 revised the subparagraph below.

c. Non-***publicly*** funded Managed Care contracts for populations other than Medicaid, CHIP, and/or other low-income individuals.

2.2.2 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 or Chief Executive Officer (CEO) 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.

Addendum 02 revised the subparagraph below.

c. A Medical Director, for physical and behavioral health, who is a Missouri-licensed physician, has or does practice medicine in the United States, is in good standing with the Missouri State Board of Medical Licensure, and 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. The Medical Director 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; shall oversee the development of clinical care standards, practice guidelines, and protocols; and shall 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 Coordinator, the Utilization Management Coordinator and the Care Management Supervisors. The Medical Director shall ensure compliance with the National Committee for Quality Assurance (hereinafter referred to as 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 (hereinafter referred to as CFO) to oversee the budget and accounting systems implemented by the health plan.

f. A full-time Quality Assessment and Improvement 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 Coordinator must have formal certification in quality improvement, risk management, or another parallel field. The physician must be Missouri licensed and have practiced or currently practice medicine in the United States. The Quality Assessment and Improvement Coordinator 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 full-time Utilization Management Coordinator who is a registered nurse, physician, or physician's assistant licensed in the State of Missouri with experience in Medicaid managed care utilization management activities. The primary duties of the Utilization Management Coordinator include development and oversight of the utilization management program in compliance with state requirements and federal regulations. The Utilization Management Coordinator 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.

h. A full-time Network Development and Management Director who is responsible for network development, sufficiency, management, and provider education and training. The Network Development and Management Director shall ensure network adequacy and timely appointment access, development of network resources in response to identified unmet needs, and ensure a member's choice of providers.

i. 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, at a minimum, the state agency, the Department of Health and Senior Services (hereinafter referred to as DHSS), local public health agencies, the Department of Mental Health (hereinafter referred to as DMH), the Department of Elementary and Secondary Education (hereinafter referred to as DESE), the Department of Social Services (DSS) - Family Support Division (hereinafter referred to as FSD), the DSS - Children's Division (CD), hospitals, the judicial system, schools, and 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 (hereinafter referred to as IEP)/Individual Family Service Plan (hereinafter referred to as IFSP). The Special Programs Coordinator is the main point of contact for members, their representatives, providers, the state agencies, and local public health agencies.

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

Addendum 02 revised the subparagraph below.

1) A Care Management Supervisor for behavioral health services that is either a Missouri-licensed Mental Health Clinical Nurse Specialist, Mental Health Nurse Practitioner, or a Missouri license***d*** Psychologist; or

2) A Care Management Supervisor for medical services that is a Missouri-licensed registered nurse.

k. A Behavioral Health Coordinator, who is licensed in the State of Missouri, and who is a Qualified Behavioral Healthcare Professional (hereinafter referred to as QBHP), as specified herein, as possesses, at a minimum, a master's degree.

Addendum 02 revised the subparagraph below.

l. Prior ***a***uthorization ***s***taff that are available to authorize services 24 hours per day, seven days per week. A Missouri-licensed registered nurse, physician, or physician's assistant shall directly supervise prior ***a***uthorization ***s***taff. Prior authorization functions for behavioral health services shall be performed and supervised by a licensed QBHP.

m. 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, or Missouri-licensed practical nurses experienced in inpatient reviews when 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.

n. 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.

o. 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.

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

q. A Claims Administrator/Management Information System (hereinafter referred to as MIS) Director to oversee claims processing, information systems functions, and data reporting necessary to support the requirements specified herein.

r. A Compliance Officer to oversee and assist with the health plan's Special Investigations Unit to manage all fraud, waste and abuse, and compliance activities.

Addendum 02 deleted words in the subparagraph below.

s. One, full-time equivalent fraud, waste, and abuse investigator per 100,000 members that shall form the health plan's Special Investigations Unit.

2.2.3 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 within the State of Missouri:

a. The Health Plan Administrator;
b. Clerical and support staff;
c. The Medical Director;
d. The Dental Consultant;
e. The CFO;
f. The Quality Assessment and Improvement Coordinator;
g. The Utilization Management Coordinator;
h. The Network Development and Management Director;
i. Care Management Supervisors;
j. The Behavioral Health Coordinator;
k. Inpatient Certification review Staff;
l. Members Services Staff;
m. Provider Services Staff;
n. The Compliance Officer;
o. The Complaint, Grievance, and Appeal Coordinator;
p. The Claim Administrator/MIS Director; and
q. Fraud, waste, and abuse investigators.
    1) The state agency may grant an exemption if the investigator lives in a bordering state.

2.2.4 The health plan shall inform the state agency in writing within seven calendar days of staffing changes in the key positions listed below. The health plan shall fill vacancies in any of such key positions with permanent, qualified replacements within 90 calendar days of the departure of the former health plan staff member.

a. The Health Plan Administrator;
b. The Medical Director;
c. A Care Management Supervisor;
d. The Quality Assessment and Improvement Coordinator;
e. The Utilization Management Coordinator;
f. The Network Development and Management Director;
g. The Special Programs Coordinator;
h. The Claims Administrator/MIS Director;
i. The Behavioral Health Coordinator;
j. The Compliance Officer;
k. The Complaint, Grievance, and Appeal Coordinator; and
l. The CFO.

2.2.5 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.

2.2.6 The health plan shall not knowingly employ as a director, officer, partner, or employee with beneficial ownership of more than 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.

2.2.7 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 (hereinafter referred to as 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.

2.2.8 Non-Discrimination in Hiring and Provision of Services:

a. Non-Discrimination and the Americans with Disabilities Act (hereinafter referred to as 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, at a minimum, the following:

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;

10) The ADA of 1990 as amended;

11) The ACA of 2010, Section 1551, the non-discrimination provision of the ACA and states that individuals cannot be subject to discrimination based on their race, color, national origin, sex, age or disability; and

12) The requirements of any other non-discrimination 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:

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 about 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 based on 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.

Addendum 02 added a word to the paragraph below.

2.2.9 All services and functions provided by the health plan or its subcontractors under the contract shall be performed in the United States in accordance with ***MO*** Executive Order 04-09 (http://s1.sos.mo.gov/CMSImages/Library/Reference/Orders/2004/eo04_009.pdf). Further, the health plan shall not store nor transmit any data related to the Managed Care Program to a site outside the United States.

2.3 Cultural Competency Requirements:

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 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 community 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 Developing Resilience and Addressing Trauma Requirements:

2.4.1 Definitions:

a. Definition of Trauma – According to the Substance Abuse and Mental Health Services Administration (hereinafter referred to as SAMHSA), "*Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."* (SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, 2014).

- A growing body of evidence documents the potential long-term negative effects of trauma on physical and behavioral health, and highlights the need for a comprehensive public health approach to develop resilience and address trauma.

b. Definition of Trauma-Informed Care – According to SAMHSA, trauma-informed care is a strengths-based approach to service delivery that, "*realizes the widespread impact of trauma and understands potential paths to recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.*" (ibid.)

2.4.2 The Missouri Model:

a. The Missouri Model – A Developmental Framework for Trauma-Informed (revised 2019) addresses the process of an organization moving along a continuum from trauma aware to trauma informed (https://www.cfechildwellbeing.org/becoming-trauma-informed).

b. The Missouri Model is guided by five key principles: safety, trustworthiness, choice, collaboration, and empowerment. It identifies key tasks for organizations as they move toward a trauma informed approach from trauma aware to trauma informed.

2.4.3 **Clarification – Trauma Informed Care and Trauma Specific Treatments -** While a trauma informed approach to providing care is an ongoing organizational change process that applies to a wide variety of organizations, trauma specific treatments refer to evidence-based treatment models for behavioral health services that address the impacts of trauma on individuals. Examples of trauma specific treatments include dialectical behavior therapy, eye movement desensitization reprocessing, and trauma-focused cognitive behavioral therapy.

2.5 Health Plan Provider Networks Requirements:

2.5.1 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, mental health providers, substance use disorder 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 the 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 (hereinafter referred to as 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 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.

d. If the health plan is unable to provide medically necessary covered services to a member in a timely manner or within applicable travel distance standards, the health plan must adequately and timely cover these services by an out-of-network provider for as long as the health plan's provider network is unable to provide these services.

2.5.2 **Network Development and Management Plan** – The health plan shall develop and maintain a Network Development and Management Plan to demonstrate that it maintains a health plan network of providers that is sufficient in number and mix in accordance with the time and distance standards and contracting requirements outlined in 20 CSR 400-7.095. The Network Development and Management Plan must also demonstrate that the health plan directly meets the needs of the anticipated and existing members in the service area and ensures the provision of covered services.

a. The Network Development and Management Plan shall, at a minimum, include the following:

1) A summary of health plan network providers by provider type and geographical location;

2) A summary of the health plan's monitoring activities to ensure that health plan network standards are met;

3) An attestation that the health plan's provider network meets network standards, or a description of the areas in which the health plan is not meeting network standards and the steps the health plan is taking to ensure network standards are met; and

4) A summary of the health plan activities to develop and expand its health plan network to better serve the needs of its members.

b. The health plan shall submit the Network Development and Management Plan to the state agency at each of the following times:

1) At the time the health plan enters into a contract with the state agency;

2) On an annual basis;

3) At any time there is a significant change, as defined by the state agency, in the health plan's operations that would affect adequacy of capacity of services, including changes in the health plan's services, benefits, geographic service area, composition of or payments to its health plan provider network enrollment of a new population in the health plan; and

4) At any time upon state agency request.

2.5.3 **Primary Care Provider (PCP) Responsibilities** – The health plan shall have written policies and procedures for all its PCP activities required herein. At a minimum, these policies and procedures shall provide for the linking of every member to a PCP, the monitoring of PCPs 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 PCPs, and notifying PCPs of their assigned member(s) prior to the member's effective date with the PCP.

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

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 care managers in developing plans of care for members receiving care management services;

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

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

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

b. PCPs may have formalized relationships with other PCPs to see their members for after-hours care, during certain days, for certain services, or other reasons to extend their practice. PCPs may also, in addition to working with the health plan's care managers, provide additional care management support for their members. However, the PCPs 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.

2.5.4 **PCPs – Eligible Specialties** – The health plan shall limit its PCPs to licensed physicians specializing in family and general practice, pediatrics, obstetrics and gynecology (hereinafter referred to as 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 the health plan's provider network.

2.5.5 PCP Teams and Primary Care Clinics – The responsibilities of a PCP team and a primary care clinic shall be the same as the responsibilities listed herein for PCPs.

a. If the health plan provider network includes institutions with teaching programs, PCP teams (comprised of residents and a supervising faculty physician) may serve as a PCP. If PCP teams are included within the health plan's provider network, the PCP 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 PCP teams 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 primary care clinics available to serve as PCPs. The primary care clinic must provide the range of services required of all PCPs. A centralized medical record shall be maintained on each member enrolled with the primary care clinic.

c. The state agency must approve the PCP teams' and PCPs' responsibilities as proposed in the LCCCP models.

2.5.6 **PCPs – Selection and Assignment** – The health plan shall offer its members freedom of choice in selecting a PCP. The health plan shall decrease the number of members assigned to a PCP if necessary to maintain the appointment availability standards described herein. To the degree possible, the health plan shall adjust the PCPs member assignments prospectively (before care has been initiated) and the health plan shall take steps to minimize the need for such adjustment to the PCPs member assignments.

2.5.7 **Specialists as PCPs** – The health plan shall allow specialists to serve as PCPS for members with disabling conditions or chronic conditions that 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.

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

2.5.9 **Behavioral Health Providers** – Behavioral Health encompasses mental health and substance use disorder treatment. To ensure a broad range of treatment options are available, the health plan shall include in its network, a mix of mental health and substance use disorder treatment providers with experience in treating children, adolescents, and adults.

a. The health plan shall include in the health plan provider network, all CMHCs within each county where the health plan has covered lives, unless otherwise authorized by the state agency. If there is

not a CMHC in that county, the health plan must contract with a CMHC within 30 miles of a county where the health plan has covered lives. If there is not a CMHC within 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 https://dmh.mo.gov/mental-illness/help/community-mental-health-centers. To the maximum extent possible, the health plan shall include all CMHCs in its network. A listing of CMHCs is provided in Attachment 6 – Federally Qualified Health Clinics, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Family Planning, and STD Providers. The health plan shall have protocols for coordinating care between PCPs and the CMHC providers. The protocols shall indicate the expected response time for consults between PCPs and the CMHC.

b. Certified Community Behavioral Health Organizations (hereinafter referred to as CCBHO) – The health plan shall include in the health plan provider network, all CCBHOs within each DMH service area. A list of the DMH CCBHOs and designated service areas may be found at the following address: https://dmh.mo.gov/media/pdf/updated-list-certified-community-behavioral-health-clinics.

c. Psychiatric Residential Treatment Facilities (hereinafter referred to as PRTFs) – The health plan shall include in the health plan provider network, both state- and privately- operated PRTFs that deliver psychiatric residential treatment services to youth with serious emotional disturbance when the youth cannot be treated in an alternative level of care.

Addendum 02 added and revised language in the subparagraph below.

d. To be considered adequate, the behavioral health provider network shall, at a minimum, include QBHPs, licensed psychiatrists, licensed psychologists, provisional licensed psychologists, licensed advanced practice psychiatric nurse practitioners, ***licensed psychiatric clinical nurse specialists,*** licensed professional counselors, provisional licensed professional counselors, licensed clinical social workers, licensed master social workers, licensed ***marital*** and family therapists and provisional licensed ***marital*** and family therapists.

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

Addendum 02 deleted and added language in the subparagraph below.

- A physician, licensed ***by the state*** 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.

Addendum 02 deleted and added language in the subparagraph below.

- A psychiatrist licensed ***by the state*** 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.

Addendum 02 deleted and added language in the subparagraph below.

- A psychologist licensed ***by the state*** to practice psychology with specialized training in behavioral health services.

Addendum 02 deleted and added language in the subparagraph below.

- A professional counselor licensed ***by the state*** to practice counseling who has specialized training in behavioral health services.

Addendum 02 deleted and added language in the subparagraph below.

- A clinical social worker licensed ***by the state*** with a Master's Degree in social work from an accredited program who has specialized training in behavioral health services.

Addendum 02 deleted and added language in the subparagraph below.

- A psychiatric nurse ***and*** a registered professional nurse, licensed ***by the state,*** who has at least two years of experience in a psychiatric setting or a Master's Degree in psychiatric nursing.

Addendum 02 deleted the subparagraph below.

- ***DELETED.***

- 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. An advanced practice nurse must also have either specialized training in behavioral health services or one year of experience, under supervision, in treating problems related to behavioral health.

Addendum 02 added the subparagraph below.

- ***A marital and family therapist licensed by the state to practice marital and family therapy.***

Addendum 02 added the subparagraph below.

- ***An advanced practice psychiatric nurse licensed by the state to practice psychiatric nursing.***

2.5.10 **FQHCs and Rural Health Clinics (hereinafter refereed to RHC) –** Federal law requires health plans to include at least one 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 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 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 state agency website. A listing of FQHCs and RHCs may be found in Attachment 6 – Federally Qualified Health Clinics, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Family Planning, and STD Providers. The health plan shall have protocols for coordinating care between PCPs and the FQHC and RHC providers. The protocols shall indicate the expected response time for consults between the FQHC, RHC, and the PCP.

2.5.11 **Family Planning and Sexually Transmitted Disease (hereinafter referred to as 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 Attachment 6 – Federally Qualified Health Clinics, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Family Planning, and STD Providers.

2.5.12 **Local Public Health Agencies (hereinafter referred to LPHA)** – The health plan shall include LPHAs in its provider network for the LPHA services described herein and for other services such as care management and services provided under the LCCCP program. A listing of LPHAs is provided in Attachment 6 – Federally Qualified Health Clinics, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Family Planning, and STD Providers. The health plan should establish an agreement with each LPHA 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 LPHAs 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 information is located and periodically updated on the state agency website.

2.5.13 Significant Network Changes:

a. The health plan shall notify the state agency within five business days, and submit an updated Network Development and Monitoring Plan, 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 PCPs by more than 5%;

Addendum 02 revised the subparagraph below.

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; and

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, at a minimum, reporting to the state agency when a provider has reached 85% of capacity.

b. If a PCP 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 PCP. The health plan shall mail this notice, with information about how to select a new PCP. Notice to the enrollee shall be provided by the later of 30 calendar days prior to the effective date of the termination or 15 calendar days after receipt or issuance of the termination notice pursuant to Managed Care Final Rule 42 CFR 438.10(f)(1).

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 by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice pursuant to Managed Care Final Rule 42 CFR 438.10(f)(1).

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.

2.5.14 **Mainstreaming** – The state agency considers mainstreaming of 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, at a minimum, 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 a 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 will 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 30 calendar days, the state will consider the health plan to have breached the provisions and requirements of the contract.

2.5.15 **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).

2.5.16 **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, at a minimum, the health plan's fee schedule, covered expenses, and quality standards. Nothing shall prevent the 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.

2.5.17 **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, stroke centers, ST-Elevation Myocardial Infarction (STEMI) centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available 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.

Addendum 03 revised the paragraph below.

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

2.5.19 **American Indian/Alaskan Natives** – The health shall ensure that American Indian/Alaskan Natives are permitted to receive care from Indian Health Care Providers (IHCP) as defined in 42 CFR 438.14. The health plan must comply with the provisions of 42 CFR 438.14 and 42 CFR 447.56.

2.6 Service Accessibility Standards Requirements:

2.6.1 24 Hour Coverage:

a. The health plan shall ensure that emergency medical/behavioral health services are available 24 hours per day, seven days per week to treat an emergency medical/behavioral health condition.

b. The health plan shall provide an accommodation, if needed, to ensure all members equal access to 24 hour per day health care coverage.

2.6.2 **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 state agency website. For those providers not addressed under 20 CSR 400-7.095, the health plan shall ensure that members have access to those providers within 30 miles, unless the health plan can demonstrate to the state agency that there is no such licensed provider within 30 miles, in which case the health plan shall ensure members have access to those providers within 60 miles. For those providers addressed under 20 CSR 400-7.095 but not applicable to the Managed Care Program, the health plan shall not be held accountable for the travel distance standards for those providers.

2.6.3 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, 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 physical or behavioral 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 24 hours.

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

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

4) Aftercare appointments within seven calendar days after hospital discharge.

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 calendar days of first request.

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

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

4) Appointments for high-risk pregnancies must be available within three 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.

2.6.4 **Access Plan** – In accordance with state requirements specified at 20 CSR 400-7.095, the health plan shall file an annual access plan, by March 1 of each year, with the Department of Commerce and Insurance (DCI) that describes the adequacy of its provider network, measures to adhere to access standard requirements, and measures to address identified access issues.

2.6.5 Prior Authorization:

a. The health plan is prohibited from requiring prior authorization for emergency medical/behavioral health 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 (hereinafter referred to as the MHPAEA), 45 CFR Parts 146 and 147 , and the CMS Final rule on MHPAEA for Medicaid.

c. The health plan shall specify, in writing, the procedures for prior authorization of non-emergency services and the timeframes in which authorizations shall 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 or behavioral health, 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 denials, reconsideration requests, and appeals must be reviewed by a professional who has appropriate clinical expertise in treating the member'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) All decisions resulting in a denial shall be easily assessable to the state for evaluation of outcomes to exclude potential adverse trends or negative impacts on member services.

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

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

7) When the health plan makes a decision that results in a denial, the health plan must notify the provider and offer an opportunity to request reconsideration. The health plan must offer a peer-

to-peer consultation within a mutually agreed upon time, within 24 hours of a provider's request for reconsideration.

8) The review process must be completed and communicated to the provider in a timely manner, as indicated below, or the denials shall be deemed approved. Services that are deemed approved must be medically necessary and are not exempt from fraud, waste, and abuse reviews and requirements. 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 provided in an emergency room setting, when determined as such by emergency room staff, shall be provided by the health plan within 30 minutes of request.

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

- Approval or denial shall be provided within 36 hours, which shall include one business day of obtaining all necessary information for routine services. The health plan shall notify the requesting provider within 36 hours, which shall include one business day following the receipt of the request of service regarding any additional information necessary to make a determination. The health plan shall not exceed 14 calendar days following the receipt of the request of service to provide approval or denial with the possible extension of up to 14 additional calendar days if the enrollee or the provider requests extension or if the health plan justifies a need (to the state agency, upon request) for additional information and shows how the extension is in the enrollee's best interest.

- Involuntary 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 Healthy Children and Youth/Early and Periodic Screening, Diagnostic, and Treatment Services (HCY/EPSDT) equipment, or augmentative communication devices) that are delivered or placed within six 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 calendar days of discharge and is appropriate to meet the medical needs of the member.

2.6.6 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 denials, reconsideration requests, and appeals.

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.

Addendum 03 revised the subparagraph below.

- For inpatient hospital admissions, continued stay reviews, and retrospective reviews to specialty pediatric hospitals, the health plan shall use the same criteria as the state agency Fee-For-Service Program found in section 13.29 ***c*** of the Hospital Provider Manual on the state agency website.

- For psychiatric inpatient hospital and PRTF admissions, continued stay reviews, and retrospective reviews, the health plan shall use the Level of Care Utilization System (hereinafter referred to as LOCUS) for members over age 18, the Child and Adolescent Level of Care/Service Intensity Utilization System (hereinafter referred to as CALOCUS-CASII) for members aged 6-18, and the Early Childhood Service Intensity Instrument (hereinafter referred to as ESCII) for members aged 0-5. If the member scores less than the current placement level but the services recommended are not available, the health plan shall continue to authorize the current level of care. In the event of disagreement, the health plan shall provide full detail of its scoring of the LOCUS/CALOCUS-CASII/ESCII to the provider of service.

- The health plan's certification review policy, procedures, and practices shall comply with the MHPAEA.

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

4) All decisions resulting in a denial shall be easily accessible to the state for evaluation of outcomes to exclude potential adverse trends or negative impacts on member services.

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

6) 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.

7) When the health plan makes a decision that results in a denial, the health plan must notify the provider and offer an opportunity to request reconsideration. The health plan must offer a peer-

to-peer consultation within a mutually agreed upon time, within 24 hours of a provider's request for reconsideration.

8) For the purpose of this section, "necessary information" shall include the results of any required face-to-face clinical evaluation or second opinion. 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.

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

10) 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 months, and medications for the prior 90 calendar days. The date, diagnosis, provider, and procedure shall be provided for each episode of care. Services related to SUD 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. Services that are deemed approved must be medically necessary and are not exempt from fraud, waste, and abuse reviews and requirements. 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.

1) Approval or denial for initial determinations shall be provided by the health plan within 36 hours, which shall include one business day, of obtaining all necessary information.

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

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

4) The health plan shall notify the requesting provider within 36 hours, which shall include one business day, following the receipt of the request of service regarding any additional information necessary to make a determination.

5) The health plan shall not exceed 14 calendar days following the receipt of the request of service to provide approval or denial for an initial or concurrent review with the possible extension of up to 14 additional calendar days if the enrollee or the provider requests extension or if the health plan justifies a need (to the state agency, upon request) for additional information and shows how the extension is in the enrollee's best interest.

2.6.7 **Behavioral Health In-Network Self-Referrals** - The health plan shall have written policies and procedures that permit members to seek in-network behavioral health services without a referral or authorization from the PCP. The policies and procedures shall permit members to contact an in-network behavioral health provider directly to access behavioral health services. The health plan shall require that the health plan's behavioral health 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 providers to refer members with physical health conditions (as indicated by the screen) to their PCP for evaluation and treatment of the physical health condition.

2.6.8 The health plan shall be prohibited from requiring prior authorization for in-network behavioral health services unless approved in advance by the state agency in writing. The health plan's request for approval

must include the list of behavioral health services the health plan is proposing to be subject to prior authorization, as well as a summary of the health plan's analysis that demonstrates that the prior authorization requirements comport with the mental health parity requirements in 42 CFR 438.910(d).

2.6.9 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, at a minimum, 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.

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.

2.7 Payments to Providers Requirements:

2.7.1 The health plan shall negotiate mutually acceptable payment rates and payment timeframes with providers so long as those rates and timeframes comply with the requirements in Sections 376.383 and 376.384, RSMo 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 herein.

2.7.2 All disputes between the health plan and in-network and out-of-network providers shall be between such providers and the health plan. In such cases, the state agency shall operate solely as an Independent Appeal Committee to which providers and the health plan shall be subject.

a. 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 with a private pay agreement.

b. If a state provider appeal is filed, per the instructions herein, the health plan shall cooperate with the state agency until a State Provider Appeal Decision is issued.

2.7.3 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 cost sharing amounts.

2.7.4 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 must inform the member that the services are not available 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 invalid.

2.7.5 **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 eligibility.

2.7.6 Claims Processing Requirements:

a. To ensure timely claims processing, the health plan shall utilize the Strategic National Implementation Process (hereinafter referred to as SNIP), minimum level of version four, in their Electronic Data Interchange (EDI).

b. The claim processing requirements applicable for purposes of a contract(s) awarded in response to this RFP, as set forth by Sections 376.383 and 376.384, RSMo (Supp. 2014).

c. The health plan shall ensure that the date of receipt is the date the health plan received the claim as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment.

d. The plan shall provide a telephone number that will be staffed during billing hours for questions from providers about refunds, recoupments, audits, cost review actions, cost containment actions and similar activities pertaining to claims and payment processes.

2.7.7 **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).

2.7.8 Psychiatric Residential Treatment Facility (PRTF) – PRTFs are entitled to reimbursement of reasonable costs from the state agency and any differential payment from the state agency.

a. The health plan reimbursement to PRTFs shall be at least the state agency Fee-for-Service fee schedule effective on the date of service. The state operated PRTF shall receive the trended cost per day as calculated by DMH for that state fiscal year.

2.7.9 Evidence-Based Practices (EBPs):

a. Enhanced reimbursement for enrolled practitioners who are certified in one or more of the following EBPs qualify for this program:

1) Eye Movement Desensitization Reprocessing (hereinafter referred to as EMDR);
2) Trauma Focused Cognitive-Behavioral Therapy (hereinafter referred to as TF-CBT); and
3) Dialectical Behavior Therapy (hereinafter referred to as DBT).

b. Enhanced reimbursement is for these EBP services delivered to members under age 21 who have experienced severe physical, sexual, or emotional trauma as a result of abuse or neglect, and for the following provider types:

1) Psychiatrist, psychiatric clinical nurse specialist (PCNS), psychiatric/mental health nurse practitioner (PMHNP);
2) Licensed psychologist, provisional licensed psychologist (PLP), doctoral psychology intern;
3) Licensed clinical social worker (hereinafter referred to as LCSW) and licensed master social worker (LMSW);
4) Licensed professional counselor (hereinafter referred to as LPC) and provisional licensed professional counselor (hereinafter referred to as PLPC); and

5) Licensed marital and family therapist (hereinafter referred to as LMFT) and provisional licensed marital and family therapist (PLMFT).

2.7.10 **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 reimbursement to FQHCs shall be 100% of the state agency Fee-for-Service fee schedule effective on the date of service.

b. The health plan shall reimburse the PBRHCs 90% of their allowable Medicaid billed charges unless the PBRHC requests a lower payment percentage.

c. The health plan shall reimburse IRHCs 100% of their Medicare/Medicaid interim rate per visit. The listing of Medicare/Medicaid interim rates per visit is located on the state agency's website: https://dss.mo.gov/mhd/providers/pages/independent-rural-health-clinic-interim-rate-list.htm.

d. The state agency shall perform reconciliation between the health plan reimbursement and the FQHCs/PBRHCs/IRHCs 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.

e. 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 of FQHCs, PBRHCs, IRHCs, and CMHCs may be found in Attachment 6 – Federally Qualified Health Clinics, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Family Planning, and STD Providers.

f. The health plan shall follow the billing instructions found in the *Companion Guide* on the state agency's website at: 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.

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

2.7.11 **Community Mental Health Centers (CMHCs)** – 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 approved as a CMHC by DMH. An example of this level of reimbursement is in Community Mental Health Center Reimbursement located on the state agency website.

2.7.12 **Certified Community Behavioral Health Organizations (CCBHOs)** – CCBHOs are certified community clinics that are required to provide a comprehensive array of community behavioral health services and are authorized under section 223 Demonstration authority through SAMHSA and the CCBHO State Plan Amendment (SPA). To recognize the CCBHOs' higher costs of doing business and their role as safety net providers, CCBHOs are reimbursed according to a Prospective Payment System (hereinafter referred to as PPS) methodology per CCBHO for qualifying encounters, and this reimbursement methodology is included in the capitation rate. The health plan shall reimburse the PPS payment to the CCBHO for all enrolled members if any covered services are provided for that day. Timely filing for CCBHO services to the health plan shall be in accordance with Section 376.384, RSMo. Behavioral Health

Services that are the responsibility of the health plan will remain the same. Prior authorizations are not required for any CCBHO service. To obtain a list of the CCBHO sites, access the DMH website at: https://dmh.mo.gov/media/pdf/updated-list-certified-community-behavioral-health-clinics.

2.7.13 **Local Public Health Agencies (hereinafter referred to as LPHAs)** - The health plan shall reimburse the LPHA (both in-network and out-of-network) according to the most current state agency program fee schedule in effect at the time of service, unless otherwise negotiated.

2.7.14 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 state agency 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 PCP or the health plan of the member's screening and treatment within ten 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, shall be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and such determination shall be final and binding on the health plan.

g. The health plan hall 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 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.

2.7.15 **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 Managed Care Program's dental and optical services. The statutory change affects the Managed Care Program's health plan reimbursement rates. Since the Missouri General Assembly appropriated funds expressly for the services required herein, the health plan shall reimburse 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 state agency Fee-For-Service fee schedule in effect at the date of service for the codes in the programs described below. The state agency 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 examinations, evaluations, treatments, and preventive pediatric and adult dental health including, at a minimum, fluoride treatment, gingivectomy, pulp treatment, root canal therapy, restorations, sealants, x-rays, and children's orthodontia.

b. The optical program provides eye examinations, serial tonometry, lenses and frames, ocular prostheses, orthotic pleoptic training or contact lenses, or any combination thereof.

c. The physician program includes services provided by qualified medical personnel in a physician's office, hospital, outpatient facility, or nursing home including, at a minimum, medical examinations, primary care, anesthesia services, surgery, diagnostic services, transplants, psychiatry, nephrology, ophthalmology, otorhinolaryngology, cardiology, physical medicine, neurology, gastrology, obesity, obstetrics, gynecology, care management, diabetes self-management training, podiatry, and pathology.

Addendum 03 revised the paragraph below.

2.7.16 **Specialty Pediatric Hospitals** – The health plan shall reimburse specialty pediatric hospitals as defined in 13 CSR 70-15.010 (2)(***O***) at no lower than the state agency Fee-For-Service fee schedule in effect at the time of service, unless otherwise negotiated with the provider.

2.7.17 **Services Delivered Outside Health Plan's Regions** – The health 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.

2.7.18 **Coverage of Preventative Health Services** – 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.

2.7.19 **Ambulance Reimbursement** – The Missouri 97th General Assembly approved a 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 providers commensurate with the Missouri General Assembly's intent.

2.7.20 **Health and Behavior Assessment and Intervention (HBAI) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services** – The health plan shall reimburse Primary Care Health Home Provider organizations for HBAI and SBIRT services provided to their members and performed by certified providers.

2.7.21 **Behavioral Health Professional Provider Reminder** – The health plan shall reimburse behavioral health providers at least 100% of the Medicaid fee schedule rate for covered professional services, except as otherwise noted.

2.7.22 **Full Medicaid Pricing –** The state agency will provide increased funding for Medicaid hospital stays and visits through the health plan capitation rates. The state agency has reviewed the aggregate funding levels for hospital inpatient and outpatient services between the Managed Care Program and the Fee-For-Service Program and has determined that an adjustment was necessary in order to ensure the capitation rate ranges reflect a sustainable pricing level. The increase to the capitation rate ranges is reflected as an adjustment to the unit cost for inpatient and outpatient services. The health plan must use the increased hospital funds detailed in Attachment 2 – Actuarial Memorandum, for reimbursement of inpatient and outpatient hospital services. For additional information on the hospital reimbursement under the state agency Fee-For-Service Program, please refer to the Fee-For-Service schedule in effect available on the state agency's website at: http://www.dss.mo.gov/mhd/providers/pages/cptagree.htm.

2.7.23 **Reimbursement for Non-Participating Hospitals** – The health plan shall reimburse non-participating hospitals 90% of the Fee-For-Service fee schedule rate effective on the date the service was provided by the hospital.

Addendum 02 revised the subparagraph below.

a. This reimbursement rate ***shall*** apply to ***non-participating*** hospitals providing behavioral health services.

b. This reimbursement rate shall not apply to any other non-participating reimbursement rates quoted under law or in a contract resulting from this RFP including, at a minimum, the following:

Addendum 02 revised the subparagraph below.

1) ***Services for*** outpatient hospital durable medical equipment;

Addendum 02 revised the subparagraph below.

2) ***Services for*** outpatient hospital laboratory services;
3) Specialty Pediatric Hospital Services, as specified herein; and
4) Emergency services provided by out-of-network providers, as specified herein.

2.7.24 **Reimbursement for Non-Participating Providers** - For providers other than hospital, the health plan shall reimburse non-participating providers 100% of the Fee-For-Service fee schedule rate effective on the date the service was provided.

a. This reimbursement rate shall not apply to any other non-participating provider reimbursement rates required under law or in a contract resulting from this RFP including, at a minimum, the following:

1) The reimbursement for non-participating hospitals, as specified herein;

Addendum 02 revised the subparagraph below.

2) The reimbursement required for emergency services provided by out-of-network ***providers***, as specified herein;

Addendum 02 revised the subparagraph below.

3) ***Services for*** outpatient hospital durable medical equipment; and

Addendum 02 revised the subparagraph below.

4) ***Services for*** outpatient hospital laboratory services.

2.7.25 **Missouri Medicaid Access to Physician Services (hereinafter referred to as MO MAPS) Program** – Effective July 1, 2018 the state agency established a program to improve access to primary care services for Managed Care Program participants. The MO MAPS Program applies to physician and certain non-physician practitioners employed by or affiliated with the following entities: University of Missouri Health System, Truman Medical Centers or University Health Physicians (formerly University Physician Associates) because these practitioners are key providers of primary care services to Managed Care Program participants.

a. Eligible providers as defined below shall be eligible for enhanced payments for patient care services provided:

1) For purposes of MO MAPS, an eligible provider shall be limited to the following providers types employed by or affiliated with the University of Missouri Health System, Truman Medical Centers, or University Health Physicians: Doctors of Medicine, Doctors of Osteopathy, Doctors of Podiatry, Doctors of Dentistry, Certified Registered Nurse Anesthetists, Certified Registered Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, Clinical Social Workers, Clinical Psychologists, Optometrists, Clinical Nurse Specialist, Assistant Physicians, Chiropractors, Board Certified Behavioral Analyst, Physical Therapist, Occupational Therapist, Speech Therapist, Audiologists, Licensed Professional Counselors, Respiratory Therapist, Acupuncturist and Registered Behavioral Technician.

b. The health plan shall continue to pay their negotiated base rates to eligible providers throughout the year.

c. The following services shall be excluded from the MO MAPS program:

1) Services provided under sub-capitated arrangements. A sub-capitated arrangement shall be defined as when a health plan pays a network healthcare practice/provider a set monthly fee that covers all the administrative and medical expenses of a defined population.

2) Services paid for under a case rate or bundled payment. Case rate/bundled payment shall be defined as either a payment of a single rate for a defined group of procedures and services (some of which may even be inpatient or outpatient) or as the reimbursement of health care providers on the basis of expected costs for clinically-defined episodes of care.

d. The health plan shall follow the MO MAPS Operations Manual for the program, which may be located and periodically updated on the state agency website at: https://dss.mo.gov/business-processes/managed-care-2023/vendor-documents/.

2.8 Comprehensive Benefit Package Requirements:

2.8.1 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 a contract(s) awarded in response to this RFP 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 shall be 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. The state agency reserves the right to modify the comprehensive benefit package at any time, via an amendment to the contract. To the extent the comprehensive benefit package is modified during the term of the contract, the capitation rates will be reviewed and adjusted if necessary and a contract amendment will advise of the new capitation rates.

2.8.2 The health plan's services shall comply with the MHPAEA, which requires parity between mental health or substance 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. At the discretion of the state agency, the health plan shall provide the state agency with detailed analyses demonstrating the health plan's compliance with MHPAEA with respect to financial requirements, quantitative treatment limitations, and non-quantitative treatment limitations. If additionally requested by the state agency, the health plan shall provide information regarding how any additional services provided by the health plan, other than those set forth in the Medicaid State Plan, are necessary for compliance with MHPAEA. The required analyses are subject to change based on the requirements outlined in 42 CFR part 438, subpart K. The health plan must comply with the following:

a. The health plan shall not have an aggregate lifetime or annual dollar limit (see 42 CFR 438.905) on any behavioral health service.

b. As specified in 42 CFR 438.910(b)(1), the health plan shall not apply any financial requirement or treatment limitation to behavioral health services in any benefit classification (inpatient, outpatient, emergency care, or prescription drugs) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all physical health services in the same classification furnished to members (whether or not the benefits are furnished by the health plan).

c. In accordance with 42 CFR 438.910(b)(2), the health plan shall provide behavioral health services in all benefit classifications.

d. The health plan shall not apply any cumulative financial requirements (see 42 CFR 438.910(c)(3) for behavioral health services.

e. In accordance with 42 CFR 438.910(d), the health plan shall not impose a non-quantitative treatment limitation (NQTL) for behavioral health services in any benefit classification unless, under the policies and procedures of the health plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to behavioral health benefits in the benefit classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL for physical health services in the benefit classification. NQTLs include, at a minimum, medical management standards; standards for provider participation, including reimbursement rates; fail-first policies; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider

specialty, or other criteria that limit the scope or duration of services; and standards for providing access to out-of-network providers (see 42 CFR 438.910(d)(2).

f. The health plan shall work with the state to ensure that all members are provided access to a set of benefits that meet the requirements of 42 CFR part 438, subpart K regarding parity in behavioral health services, regardless of what behavioral health services are provided by the health plan.

g. The health plan shall cooperate with the state agency to establish and demonstrate initial and ongoing compliance with 42 CFR part 438, subpart K regarding behavioral health parity. This shall include, at a minimum, participating in meetings, providing information (documentation, data, etc.) requested by the state agency to assess parity compliance, working with the state agency to resolve any non-compliance, and notifying the state agency of any changes to benefits or limitations that might impact parity compliance.

2.8.3 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 and periodically updated on the state agency website.

2.8.4 **Provider Preventable Conditions** – Services falling under a Provider Preventable Condition (hereinafter referred to as PPC) category shall be denied state agency reimbursement and the health plan shall be responsible for the payment for any item or service related to a PPC. The state agency will follow CMS guidelines regarding PPCs. A member shall not be liable for payment for any item or service related to a PPC. The health plan shall ensure that providers report PPCs as required by 13 CSR 70-3.230. The health plan shall submit all identified PPCs to the state agency in the format and for the time specified.

a. The health plan shall process claims that include Health Care-Acquired Conditions (HCACs) using the All Patient Refined Diagnosis Related Group (APR DRG) software and adjust claims if needed. The health plan may adjust claims prospectively or retrospectively.

b. The health plan shall report their PPCs in a format and frequency specified by the state agency in the Provider Preventable Conditions report located and periodically updated on the state agency website under Reporting Schedule and Templates.

2.8.5 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 and periodically updated on the state agency website.

a. Ambulatory surgical center, birthing center.

b. Asthma education and in-home environmental assessments - The health plan shall provide asthma education and in-home environmental assessments according to state agency policy.

c. Behavioral health services – For purposes of a contract(s) awarded in response to this RFP, behavioral health services are defined to include services that address mental health conditions and/or SUD.

1) The health plan shall provide all medically necessary behavioral health services included in the comprehensive benefit package. The state agency, in conjunction with DMH, 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, at a minimum, the following:

- Inpatient psychiatric facility services. Inpatient psychiatric services for individuals under age 21 must comply with Federal regulations 42 CFR 441 Subpart D and 42 CFR 483 Subpart G and must involve:
  - ✓ Medical, psychiatric, and social evaluation;
  - ✓ Certification of need for services;
  - ✓ Professionally developed, individualized plan of care; and
  - ✓ Active treatment involving implementation of the plan of care.

    - Covered settings for individuals under age 21 include acute care hospitals with psychiatric units, private and state psychiatric hospitals, and PRTF. Covered settings for individuals aged 21 through 64 include acute care hospitals and freestanding psychiatric hospitals with 16 or fewer beds. See the In Lieu of Service or Settings section herein for conditions under which inpatient psychiatric services may also be provided in an Institution for Mental Diseases (IMD).

- PRTF services provides by a private PRTF or state-operated PRTF. PRTFs provide non-acute inpatient facility care for individuals under age 21 with mental health conditions and/or SUD.

- Outpatient behavioral health services when provided by a licensed psychiatrist, licensed or provisional licensed psychologist, LCSW, LMSW, licensed or provisional licensed professional counselor, licensed advanced practice psychiatric nurse, supervised psychology intern, licensed or provisional licensed marital and family therapist, and Missouri certified behavioral health programs. 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 telephone or videoconference contacts, home visits, and other electronic communications.

- Crisis intervention/access services including, at a minimum, (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 care management services.

2) To the extent permitted by state and federal law, the health plan shall notify the member's PCP when a member is admitted for behavioral health services.

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

4) The health plan shall provide the behavioral health services defined herein that are court ordered, including 96 hour detentions for involuntary commitments.

5) Behavioral Health Out-of-Network referrals – If the health plan believes that a member who is not enrolled in the Specialty Plan, 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 Behavioral Health for placement in accordance with the state agency's Managed Care policy statement entitled, *Service Coordination for Behavioral Health Services Not Covered by MO HealthNet Care Health Plans*, located within the state agency's Managed Care Policy Statements document found on the following website: https://dss.mo.gov/business-processes/managed-care-2023/vendor-documents/

d. Chiropractic Services – The health plan shall provide members with chiropractic services to include examinations, diagnoses, adjustments, and manipulations and treatments of malpositioned articulations and structures of the body.

e. Complementary Health and Alternative Therapy for Chronic Pain Management – The health plan shall provide members aged 21 and older complementary health and alternative therapy for chronic pain management services that include physical therapy, cognitive-behavioral therapy (hereinafter referred to as CBT), chiropractic therapy, and acupuncture.

f. Dental services related to trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury; treatment of a disease/medical condition without which the health of the individual would be adversely affected; preventive services; restorative services; periodontal treatment; oral surgery; extractions; radiographs; pain evaluation and relief; infection control; and general anesthesia.

g. Diabetes Prevention Program (DPP) – The health plan shall provide members aged 21 and older diabetes prevention services.

h. Durable medical equipment including, at a minimum, 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 IEP or IFSP.

i. Early and Periodic Screening, Diagnostic, and treatment Services (hereinafter referred to as 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 20. Independent foster care adolescents with a Medical Eligibility code of 38 and who are aged 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 (hereinafter referred to as 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 21, and conduct and document well child visits (screenings) using the state agency's HCY/EPSDT screening form, as amended, or through an electronic medical record. (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 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 visit 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 months and continuing through age 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;

Addendum 02 revised the subparagraph below.

- Blood lead level (hereinafter referred to as BLL) testing is mandatory at 12 and 24 months of age for all children covered under ***the*** Managed Care Program**,** or annually for all children six months to 72 months of age if residing in an area designated as high risk for lead poisoning in Missouri as defined by DHSS regulation 19 CSR 20-8.030;
- Hearing screening;
- Vision screening; and
- Dental screening (oral exam by PCP as part of comprehensive exam). Recommended that preventive dental services begin at age six through 12 months and be repeated every six 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 to 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.
- Preventative pediatric visits according to the periodicity schedule inclusive of a verbal lead assessment and blood lead tests.
- Diagnosis and 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, at a minimum, 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 30 calendar days of health plan enrollment to provide assistance in accessing HCY/EPSDT well child visit services. The health plan shall assist 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, and 97, non-emergency medical transportation shall not be 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 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 in 13 CSR 70-25.110, 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 97) 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 will use such encounter data submissions and other data sources to determine health plan compliance with CMS requirements that 80% of eligible members under the age of 21 are receiving HCY/EPSDT well child visits in accordance with the periodicity schedule. The state agency will use the participant ratio as calculated using the CMS 416 methodology for measuring and auditing the health plan's performance.

Addendum 02 deleted the subparagraph below.

- ***DELETED.***

- 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 Health Plan Administrator or Chief Executive Officer;
  - ✓ The health plan's CFO; or
  - ✓ An individual who has been delegated authority to sign for, and who reports directly to the health plan's CEO or CFO;

    - 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.

Addendum 03 inserted the subparagraph below.

- ***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 EPSDT Screening Codes located and periodically updated on the MO HealthNet Managed Care website under 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.

10) Additionally, the health plan shall meet a 65% participant ratio for two age categories. The two age categories are newborns (infants less than one year old) and children ages one through less than six. This requirement is subject to audit and the reporting requirements herein.

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

j. Emergency Medical, Behavioral Health, and Post-Stabilization Care Services:

1) Emergency medical or behavioral health services means covered inpatient and outpatient services that shall be (1) furnished by a provider qualified to furnish these services and (2) needed to evaluate or stabilize an emergency medical condition. For purposes of this document, an emergency medical condition shall be defined as a medical or behavioral health 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 part or organ;
- Serious harm to self or others due to an alcohol or drug use 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) For purposes of this document, post-stabilization care shall be defined as covered services related to an emergency medical condition that shall be provided after a member is stabilized in order to maintain the stabilized conditions or to improve or resolve the member's condition.

k. 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.

l. Home Health Services – The health plan shall provide physician ordered home health services to members as necessary. Home health services shall include skilled nurse visits, home health side visits, and provision medical supplies.

m. Hospice Services – The health plan shall provide hospice services for children (ages 0-20) that shall be concurrent with the care related to curative treatment of the condition for which a diagnosis of a terminal illness has been made.

n. Inpatient Hospital Services – The health plan shall provide inpatient hospital services to members as necessary. A hospital stay shall be considered inpatient upon the issuance of written physician orders to such effect. The service shall be considered inpatient if the intent shall be for the member to stay in the hospital for 24 hours or longer, even if the member dies, is discharged, or is transferred to another institution and does not actually spend a full 24 hours in the hospital.

o. Laboratory, Radiology, and Other Diagnostic Services – The health plan shall provide laboratory, radiology, and other diagnostic services to members, as necessary. Laboratories that perform laboratory procedures for the state agency must be registered with the state to perform the required laboratory procedures.

p. LPHA Services – Are responsible for the following services provided by in-network providers and at LPHAs, whether in-network or out-of-network:

1) STD Services - All STD services including screening, diagnosis, and treatment. In-network providers shall follow current Centers for Disease Control and Prevention (hereinafter referred to as the 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 (hereinafter referred to as PID).
- Diagnosis and preventative treatment of members who are reported as contacts/sex partners of any person diagnosed with an STD. The member shall be given the option of seeing an in-network provider first.
- The LPHA shall encourage members to follow-up with their PCP; however, if the member chooses follow-up care at the LPHA for confidentiality reasons, the health plan shall reimburse the local public health agency for follow-up office visits (not to exceed three visits per episode).

2) Human Immunodeficiency Virus (hereinafter referred to as HIV) Services - 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 of tuberculosis infection or tuberculosis disease. Such services shall be in accordance with the medical criteria outlined in the most current guidelines from the CDC (https://www.cdc.gov/tb/publications/guidelines/default.htm), which may be coauthored, by the American Thoracic Society and Infectious Diseases Society of America.

- Testing methods for tuberculosis infection and/or tuberculosis disease include the use of the Mantoux PPD or FDA-approved interferon Gamma Release Assay (IGRA). Providers shall follow current CDC recommended testing guidelines.

- The health plan shall report all members diagnosed with tuberculosis infection or tuberculosis disease to the LPHA.

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

- All laboratory tests performed for tuberculosis shall meet the standards established by the CDC and the Missouri DHSS (Missouri DHSS, Tuberculosis Case Management Manual: https://health.mo.gov/living/healthcondiseases/communicable/tuberculosis/tbmanual/index.php). Sensitivity tests shall be performed on all initial specimens positive for M. Tuberculosis. DHSS recommends all tuberculosis sputum specimens be submitted to the Missouri State Public Health Laboratory. Any positive cultures for M Tuberculosis isolated at private laboratories should be sent to the Missouri State Public Health Laboratory pursuant to 19 CSR 20-20.080.

- The CDC recommends that providers treating members with drug resistant tuberculosis consult with a national expert for appropriate treatment recommendations. The Missouri DHSS Tuberculosis Elimination Program shall facilitate contact with a national expert familiar with treating drug resistant tuberculosis disease. The Missouri DHSS Tuberculosis Elimination Program contacts can be found at https://health.mo.gov/living/healthcondiseases/communicable/tuberculosis/.

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 will provide the health plan's Medical Director with copies of the most recent recommendations immediately following the state agency's notification to the health plan to proceed with contract services, upon request, and when the recommendations change.

- The health plan and its in-network providers shall enroll and obtain vaccines through the Missouri DHSS Vaccines for Children (hereinafter referred to as VFC) Program or any such vaccine supply program as designated by the state agency. Any time a member receives immunizations from a LPHA, or at a Special Supplemental Nutrition Program for Women, Infants, and Children (herein after referred to as WIC) site, the health plan shall reimburse only the cost for administration at the current Managed Care Program rates in effect at the time of the service, unless otherwise negotiated. Members with ME codes 73 through 75, and 97 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 other vaccine supply program as designated by the state agency when the vaccine is deemed medically necessary. However, the COVID-19 vaccine and the administration of the vaccine shall be carved out and provided through the Fee-For-Service Program and reimbursed by the state agency according to the terms and conditions of the program.

Addendum 02 deleted language in the subparagraph below.

- The health plan shall collaborate with the state agency and the Missouri DHSS to determine the health plan's aggregate immunization level. The Missouri DHSS, Immunization Program will offer consultation 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 and CDC guidelines: Screening Young Children for Lead Poisoning and Managing Elevated Blood Lead Levels Among Young Children. DHSS will provide the health plan's Medical Director with copies of current protocols and guidelines immediately following the state agency's notification to the health plan to proceed with contract services and 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.

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

1) The health plan shall provide coverage for a minimum of 48 hours of inpatient hospital services following a vaginal delivery and a minimum of 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. 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 first post-discharge visit shall occur within 24 to 48 hours of discharge. 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, at a minimum, 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 health 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 such guidelines prior to implementation of its use.

r. Obesity – The health plan shall provide treatment for obesity in children and adults according to state agency policy.

s. Optical Services – The health plan shall provide one comprehensive or one limited eye examination every two years for refractive error, services related to trauma or treatment of disease/medical

condition (including eye prosthetics), and one pair of eyeglasses every two years (during any 24 month period of time).

t. Outpatient Hospital Services – The health plan shall provide outpatient hospital services to members, as necessary. These services are provided to members not admitted to the hospital as an inpatient, but that are registered in hospital records as outpatient and receiving services from the hospital.

u. Personal Care Services – The health plan shall provide personal care services for members, as necessary. Personal care services shall include basic personal care (i.e. eating, bathing, dressing, activities of daily living), advanced personal care (i.e. removal of catheters, help with medications), and authorized nurse visits.

v. 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 a member requests a home birth, the health plan shall notify the state agency so that the member may be disenrolled from the Managed Care Program and enrolled in the Fee-For-Service Program.

w. Podiatry Services – The health plan shall provide podiatry services, with the exception of trimming of nondystrophic nails, any number; debridement of nail(s) by any method(s), one to five; debridement of nail(s) by any method(s), six or more; excision of nail and nail matrix, partial or complete; and strapping of ankle and/or foot.

x. Tobacco Cessation Counseling Services – The health plan shall provide individual and group tobacco cessation counseling for its members.

y. Transplant Related Services:

1) 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 shall be prior authorized by the state agency and must be performed at a state agency's approved transplant facility in accordance with the Managed Care Program 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 PCP 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 Managed Care Program rates in effect at the time of the services.

2) If there is a significant change in diagnosis not related to the transplant during the transplant stay, the health plan shall be responsible for those services not related to the transplant. Any additional services not related to the transplant shall be considered post-transplant services and the responsibility of the health plan.

z. 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, and 97 (Refer to Category of Aid 5 in Attachment 1, MO HealthNet Managed Care and Related Eligibility Groups, for members 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 Fee-For-Service Program covered services not included in the comprehensive benefit package.

aa. Treat no Transport (TNT) Services – The health plan shall provide on-site and/or referral treatment services by emergency medical staff for members not transported to the emergency department.

2.8.6 **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. The outreach or education materials related to cancer screenings are subject to a compliance audit at the discretion of the state agency.

2.8.7 **Additional Services** – In addition to the services listed in the comprehensive benefit package herein, the health plan shall provide the following services to:

a. Children under 21 years of age and pregnant women with ME codes 18, 43, 44, 45, 61, 95, 96, and 98:

1) Comprehensive day rehabilitation (for certain persons with disabling impairments as the result of a traumatic head injury);

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

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

4) Hearing aids and related services;

5) Optical services to include one comprehensive or one limited eye examination per year for refractive error, one pair of eyeglasses every two years, replacement lens(es) when there is a .50 or greater change and, for children under age 21, replacement frames or lenses, or both when lost, broken or medically necessary, and HCY/EPSDT optical screen and services;

6) Podiatry services;

7) Services that are included in the comprehensive benefit package, medically necessary, and not identified in the IFSP or IEP; and

8) Therapy services (physical occupational, and speech).

b. Adults age 19 to 64 years of age, also known as the Adult Expansion Group (hereinafter referred to as AEG):

1) Habilitative Services – Physical, occupational, and speech therapy services:

- For adults 19 to 20 years of age, services may be delivered under EPSDT, and/or habilitative benefits not part of an EPSDT program, and members shall not subject to a limitation on the number of visits.

- For adults 21 to 64 years of age, services shall be delivered under the habilitative benefit referenced herein, and members are subject to a maximum of 20 visits on a rolling year basis.

  ✓ For purposes of this document, a rolling year shall be defined as 12-month period measured backwards from the date the service was first received.

c. The state agency reserves the right to modify the additional screening services required herein at any time, via a contract amendment. To the extent the additional screening services required herein are modified during the term of the contract, the capitation rates will be reviewed and adjusted as necessary and the contract amendment will advise of new capitation rates.

2.8.8 **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 may 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 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.

Addendum 02 deleted a repetitive word from the paragraph below.

2.8.9 **Additional Health Benefits** – In accordance with 42 CFR 438.3(e)(1)(i), 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. The health plan shall understand and agree that the additional health benefits identified in the health plan's awarded proposal shall be subject to the state agency's final review and approval. A list of Additional Health Benefits for each region is located and periodically updated on the state agency website. 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 not portray required comprehensive benefits or services as an additional health benefit. The Additional Health Benefit Template is located on the state agency website.

a. The health plan shall develop educational materials for members, parents/guardians and providers that educate them about how these additional health benefits will be administered and provide information about any administrative requirements (e.g. prior authorization requirements, etc.).

b. The outreach or education materials related to the approved additional health benefit may be subject to a compliance audit at the discretion of the state agency.

c. The health plan shall notify the state agency and members receiving additional health benefits no less than 30 calendar days prior to discontinuing or reducing such benefits. Members do not have the right to appeal the denial of additional health benefits.

2.8.10 **In Lieu of Services of Settings (hereinafter referred to as ILOS)** – An in lieu of service or setting is an alternative service or setting that the state agency, in accordance with 42 CFR 438.3(e)(2) and any applicable state regulations, determines to be a medically appropriate and cost effective substitute for a covered service or setting under the Medicaid State plan. To the extent the health plan would like to offer an ILOS, the health plan must submit a written request to the state agency for such service or setting and the state agency will make a determination if the alternative service or setting meets the criteria for an ILOS.

Please see In Lieu of Services Application located and periodically updated on the state agency website. If approved, the health plan may offer the ILOS to members, as appropriate, but may not require a member to use an ILOS. In accordance with 42 CFR 438.3(e)(2)(iv), the utilization and actual cost of approved ILOS will be taken into account in developing the component of the capitation rate that represents the covered Medicaid State plan services.

a. The health plan shall develop educational materials for members, parents/guardians and providers that educate them about how these benefits will be administered and provide information about any administrative requirements (e.g. prior authorization requirements, etc.).

b. The outreach or education materials related to the approved ILOS are subject to a compliance audit at the discretion of the state agency.

c. The health plan shall notify the state agency no less than 30 calendar days prior to discontinuing an approved ILOS. The health plan shall notify all enrollees receiving an alternative service or setting no less than ten calendar days prior to discontinuing an ILOS.

d. The health plan shall submit a copy of its procedures for in lieu services to the state agency for approval in advance of implementation.

e. The health plan may offer the following services under this section:

1) IMD Services – The health plan may offer an inpatient stay in an IMD setting of no more than 15 days of the month for covered inpatient psychiatric or SUD services to members aged 21-64.

2) Medical Day Care – The health plan may offer Medical Day Care in lieu of Private Duty Nursing.

2.8.11 **Short-Term Inpatient Stays in an IMD** – In accordance with 42 CFR 438.6(e), the health plan may offer an inpatient stay in an IMD, as an in lieu of setting, of no more than 15 days within the month for covered inpatient psychiatric or SUD services to members between ages 21-64. In accordance with 42 CFR 438.3(e)(2)(ii)-(iii), the health plan may not require a member to receive inpatient psychiatric or SUD services in an IMD and the health plan is not required to use the IMD as an in lieu of setting. For purposes of rate setting, the state agency will consider member utilization of covered inpatient psychiatric or SUD services in an IMD when developing the respective component of the capitation rate; however, IMD utilization will be priced at the cost of the same services through providers included in the Medicaid State plan. No FFP will be claimed for the month in which the member's stay in an IMD exceeds 15 calendar days.

2.8.12 **Initial Screening** - The health plan shall make their best effort to conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the member is unsuccessful.

2.8.13 **Programs Needing Prior Approval** – The health plan must receive prior approval before providing services in alternative formats. Examples include in-home test kits, cognitive behavior therapy apps, health check and chatbot apps, telehealth apps, and general health education through apps or social media. The health plan must assure that the use of these methods do not substitute for required comprehensive services or supplant the provider-member relationship, and must ensure that members receive services in a safe and effective manner.

a. The health plan shall develop educational materials for members, parents/guardians and providers that educate them about how these new programs will be administered.

b. The outreach or education materials related to the approved new program are subject to a compliance audit at the discretion of the state agency.

c. The health plan shall notify the state agency and members receiving new programs no less than 30 calendar days prior to discontinuing or reducing such benefits.

2.9 Second Opinion Requirements – 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 PCP or self-referral. RSMo 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.

2.10 Release for Ethical Reasons Requirements:

2.10.1 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.

2.10.2 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 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.

2.11 Coordination with Services Not included in the Comprehensive Benefits Package Requirements – The health plan shall not be obligated to provide or pay for any services not included in the comprehensive benefits package. Information about some of the services not in the comprehensive benefits package is provided below. The health plan shall be responsible for coordinating the provision of services in the comprehensive benefits package with services not included within the comprehensive benefits package.

2.11.1 **Abortion Services** – Abortion services subject to Managed Care 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 Managed Care Program.

2.11.2 Adult Day Care Waiver:

a. Home and community based waiver services for Adult Day Care (hereinafter referred to as ADC) Services include, at a minimum, 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 shall be made for up to 120 minutes per day of transportation that is related to transporting the member to and from the ADC setting. Meals provided as part of ADC shall not constitute a "full nutritional regimen" (three meals per day).

b. The health plan shall be responsible for Managed Care Program comprehensive benefit package services for ADC waiver clients enrolled in the Managed Care Program, 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/hcbs/adhcproposalpackets.php.

2.11.3 Comprehensive Substance Abuse Treatment Rehabilitation (hereinafter referred to as C-Star) Services:

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

b. In order to ensure quality of care, the health plan and its behavioral health 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 Fee-For-Service Coordination and the Substance Use Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care* policy statement in the MO HealthNet Managed Care Policy Statements located and periodically updated on the state agency website.

2.11.4 Behavioral Health Services:

a. Services provided by Psychiatric Rehabilitation provider shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the Managed Care Program.

b. Behavioral health adult targeted care management services shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the Managed Care Program.

c. Applied Behavior Analysis (ABA) services for children with Autism Spectrum Disorder shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the Managed Care Program.

2.11.5 Developmental Disabilities (hereinafter referred to as DD) Waiver Services:

a. Home and community based waiver services for persons in the DD waiver are carved out of the Managed Care Program. There are four waivers operated by the DMH, Division of Developmental Disabilities. Three of the waivers may include individuals in Managed Care. Home and community based waiver services vary from waiver to waiver and may include, at a minimum, 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 the Managed Care Program comprehensive benefit package services for DD waiver clients enrolled in the Managed Care Program, 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 the DD Waiver Provider Manual located on the internet at: http://manuals.momed.com/manuals/; in the

Provider Bulletins located on the internet at: http://www.dss.mo.gov/mhd/providers/pages/bulletins.htm, on the Managed Care Program website, and in the *Waivers Operated by the Department of Mental Health,* which may include Managed Care Individuals.

2.11.6 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 Managed Care 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. For purposes of this document, the carve out of pharmacy services shall be 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 Managed Care Program Pharmacy Program. The Managed Care Program 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 Managed Care Program 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 Managed Care Program Pharmacy Program will cover the pharmacy service when billed on a pharmacy claim form including all of the appropriate information such as, at a minimum, 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 Managed Care Program Pharmacy Program covers medications for tobacco cessation. Medications given during an observational unit status, but not during an inpatient hospital stay, will be covered by the Managed Care Program Pharmacy Program.

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 36 contiguous months (including, at a minimum, 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 with 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.

2.11.7 **Public Health Program** – Services offered by DHSS and LPHAs 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 Managed Care 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 DHSS designated LPHA 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 Managed Care Program. Such costs shall not be included in the Medicaid State plan capitated rates.

Addendum 02 added a word to the subparagraph below.

c. Newborn Screening Collection Kits – According to Section 191.331, RSMo health care providers must purchase pre-paid newborn screening collection kits from DHSS. DHSS sells the kit to providers. When the provider submits a specimen to the State DHSS Laboratory, the laboratory shall process the test, determine if the member is ***MHD*** Managed Care Program eligible, and bill the state agency for the test.

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

1) 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.

2) 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 may be found on the Department of Health and Senior Services WIC web page at: http://health.mo.gov/living/families/wic/.)

2.11.8 **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 Managed Care 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 Managed Care 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.

2.11.9 Services in an Educational Setting:

a. School-Based Direct Services – These services are provided directly by schools.

1) The health plan shall not be financially liable for physical therapy (hereinafter referred to as PT), occupational therapy (hereinafter referred to as OT), speech therapy (hereinafter referred to as ST), hearing aids, personal care, private duty nursing, or behavioral health services included in an IEP developed by the public school. IEPs include services that are needed due to developmental and educational needs.

2) The health plan shall be financially liable and shall not delay the provision of any medically necessary services pending completion of the IEP. The health plan shall have a written process for coordination with school districts for both IEP services and services provided outside the IEP

including, at a minimum, services provided at the school and school based health clinic services. The health plan shall be responsible for medically necessary services provided outside of the IEP including, at a minimum, services provided at the school and school based health clinic services.

3) The health plan may refer children who are potentially eligible for IEP services to the school district in which the child resides.

4) School-based direct services are required under the Individuals with Disabilities Education Act (hereinafter referred to as IDEA) – Part B (34 CFR 300), which also defines the IEP. The IEP determines the child's service needs. A child must meet eligibility as defined by IDEA in order to receive school-based direct services. Eligibility criteria and school district contract information may be found on the DESE website at https://dese.mo.gov/special-education.

b. First Steps Program:

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

2) The health plan shall be responsible for medically necessary services provided to Managed Care Program participants outside of the IFSP, and shall not delay the provision of any medically necessary services pending completion of the IFSP. The health plan shall have a written process for coordination and collaboration with the System Point of Entry (hereinafter referred to as the SPOE).

3) The health plan may refer children who are potentially eligible for First Steps services to the SPOE office in the region where the child resides. A listing of SPOE office may be found on the DESE website at: https://dese.mo.gov/media/pdf/first-steps-spoe-contact-information-region

4) First Steps services are required by IDEA - Part C (34 CFR 303) which also defines the IFSP. An infant or toddler must meet eligibility criteria as defined by DESE in order to receive First Steps services. 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 (SPOE) or call the statewide toll-free number, 866-583-2392, to make a referral. Eligibility criteria and SPOE office contact information may be found on the DESE First Steps website at https://dese.mo.gov/childhood/early-intervention/first-steps.

c. Parents as Teachers (hereinafter referred to as PAT) – 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. The PAT program is administered at the local level by all public school districts in Missouri. School district contact information may be found on the DESE website at https://dese.mo.gov/.

1) The health plan shall not be financially liable for services provided by the PAT program.

2) The health plan may encourage in-network pediatric providers to make referrals to the PAT program.

2.11.10 Transplant Services – The health plan shall coordinate services for a member requiring a transplant. Solid organ and bone marrow/stem cell transplant services shall be paid for all populations on a fee-for-service basis outside of the comprehensive benefit package. Transplant services covered by fee-for-service shall be 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 and periodically updated on the state agency website.

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. If there is a significant change in diagnosis not related to the transplant during the transplant stay, the health plan shall be responsible for those services not related to the transplant. Any additional services not related to the transplant shall be considered post-transplant services and shall be the responsibility of the health plan.

d. 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.

2.12 Member Care Management – Disease Management (hereinafter referred to as DM), Hospital Care Transition (hereinafter referred to as HCT), and Transition of Care (hereinafter referred to as TOC) Requirements:

2.12.1 **Member Care Management (hereinafter referred to as CM)** – The health plan shall provide Member CM, which will focus on improved health outcomes and the overarching patient experience. CM shall utilize an integrated physical and behavioral health approach as well as member/family support in the management of complex physical and behavioral health conditions. Member CM includes DM, HCT, and TOC as appropriate.

a. **Principles of Member CM** - Services shall incorporate the following principles:

1) A 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 including but not limited to assessing member needs related to social determinants of health (SDOH);

2) Comprehensive care planning including stated member/family centered activities, measurable, defined goals, interventions and evaluation of progress;

3) Provision of education to facilitate understanding of CM process;

4) Application of clinical knowledge to the member's qualifying condition to attain resolution, improvement or support during the CM process;

5) Incorporation of shared goals meant to achieve improved quality, and clinical and cost outcomes including appropriate utilization of resources and medical management;

6) Inclusion of member/family education to help facilitate attainment of skills and resources needed to address member/family goals;

7) Promotion of preventative service utilization to help ensure quality outcomes for members;

8) Identification and planning interventions as needed to ensure appropriate utilization practices;

9) Coordination of TOC efforts whether the transition is movement through various health systems or health care payers;

10) Incorporation of DM services if the qualifying event for DM is being managed along with other qualifying criteria;

11) Promotion of the provision of CM by local, community-based care management entities;

12) The health plan shall use a Section 2703 designated health home provider or LCCCP provider to perform CM services if the health home and LCCCP provider are members of the health plan network; and

13) The health plan shall have processes in place to monitor service delivery to ensure at least minimum requirements for CM services are met.

b. Member CM Program Requirements:

1) The health plan's CM staff shall be composed of individuals with diverse specialties and experience with the kinds of conditions that precipitated the need for CM;

2) The health plan must be able to demonstrate their CM staffing requirements and provide a formula used to determine CM staff to patient ratios;

3) The health plan shall integrate physical health and behavioral health CM staff;

4) The health plan's CM approach shall include both consistent interpersonal engagement as well as integrated CM systems with evidence of documentation in the member's Care Plan;

5) The health plan shall utilize support staff integration through activities including, at a minimum, case conferences, development of multidisciplinary, and shared Care Plans;

6) The health plan shall provide a detailed CM Plan at the time of the readiness review and shall obtain the state's approval prior to implementation. Annually thereafter, the health plan shall provide an updated plan by July 1. The update shall include an evaluation of the health plan's CM effectiveness and provide adjustments for the upcoming year;

7) The health plan shall participate in an annual CM evaluation that is based on the patient Journey model. The state will provide additional information regarding this model following the contract award.

c. **CM Record Documentation** – CM record documentation shall include, at a minimum, the following:

1) How the member qualifies for CM outreach (e.g., tier assignment, disease process, behavioral health support, pregnancy, etc.);

2) Referrals;

3) Assessment/Reassessment;

4) Medical history;

5) Psychiatric history;

6) Developmental history;

7) Medical conditions;

8) Psychosocial issues;

9) Social determinants of health (e.g., housing, food insecurity, environmental impacts, etc.);

10) Legal issues;

11) Cultural and linguistic needs;

12) Care Planning which is shared with the PCP or designee and other health professional(s) involved in the member's care and demonstrates a mechanism to allow for provider updates and communication with CM staff;

13) Evidence of Care Plan updates at least quarterly and following any change to the Care Plan as a result of: member/family touch, provider interaction, service utilization, and any other pertinent event;

14) Testing, including results;

15) Progress/contact notes;

16) Discharge plans including changes or resources needed specific to the episode of care;

17) Aftercare including post-acute care needs;

18) TOC coordination which includes transitions between health care facilities as well as health care payers;

19) Coordination/linking services;

20) Monitoring of services and care;

21) Follow-up;

22) Evidence of preventative services promotion; and

23) A listing of each distinct condition for which the member is being managed, including the start and stop date for each condition.

d. **General Health Plan Policy Requirements** – The health plan shall have policies and procedures in place for CM that include, at a minimum, the following:

1) If the health plan wants to use LPHAs to provide services, the health plan shall enter into written contracts as well as develop and provide written policies describing the scope of care with the LPHAs. (The health plan shall not be required to contract with outside entities for prenatal care management activities);

2) A description of the system for identifying, screening, and selecting members for each individual CM service including risk stratification;

3) A description of the mechanism for which members are informed of CM services and information communicated which includes, at a minimum, the following:

- The nature of the CM relationship and the impact it may have on positive member outcomes;

- The goal of CM which includes engagement to empower members and encourage their participation in their own plan of care through goral setting and integrated pathway management to improve outcomes and the overarching patient experience;
- Circumstances under which information will be disclosed to third parties;
- The availability of a complaint process; and
- The rationale for implementing CM services.

4) A description of provider and member profiling activities;

5) A description of procedures for conducting provider education on CM services to ensure provider support and contribution to member education;

6) A description of a standardized Care Planning process, which includes documentation consisting of, at a minimum, the following:

- Addition or removal of Care Plan goals;
- Achievement of or failure to reach collaborative goals;
- Interventions and closures to CM;
- Evidence of use of clinical practice guidelines (including CyberAccess) to monitor progress and other pertinent changes to the care plan;
- Evidence of routine Care Plan updates at least quarterly and following every member/family touch, provider interaction, service utilization, and any other pertinent event;
- Evidence of member/family engagement and collaborative efforts to empower members and their families to promote ownership of health outcomes; and
- Mechanism to track CM activities whether they be DM related or any other CM activity.

7) A description of the type of data and information (e.g., health plans claims data, readmissions, prescription drug utilization data) and how the health plan will use the data to inform CM (i.e., individually and systemically);

8) A description of the mechanism to ensure that the PCP, member parent/guardian, case worker, specialists caring for the member and any other discipline contributing to the integrated treatment approach have access to the plan of care;

9) A description of the mechanism used to evaluate CM services that have been contracted by third party entity to ensure at least minimum standards for CM delivery are being met;

10) A description of mechanism in place to ensure coordination and communication between physical and behavioral health providers is available to support an integrated service delivery approach;

11) A description of the protocols for communication and responsibility sharing in cases where more than one Care Manager is assigned;

12) A description of the methodology used for assigning and monitoring CM caseloads that ensures adequate staffing to meet CM requirements;

13) A description of Care Manager training and stated qualifications needed to effectively manage care across the integrated healthcare spectrum;

14) A description of evaluation process to determine efficacy of CM services;

15) Criteria for CM closure and mechanism for PCP notification of closure;

16) A description of documented adherence to any applicable state quality assurance, certification review standards, and practice guidelines, as described herein; and

17) A description of the mechanism used to be able to report each and every condition for which a member is being managed, including stop and start dates for each condition.

Addendum 02 added the following subparagraph and bullet points.

18) Adequately addressing case and CM of medically complex members. These specific members may be determined medically complex by having one or more advanced medical support needs or as identified through assessment as outlined in the Private Duty Nursing Manual. In addition, the health plan, care managers, or a combination of both shall ensure the following:

- ***Coordinating services, such as private duty nursing (PDN), home health, etc. and ensuring that members are receiving all medically necessary services;***
- ***Coordinating, referring, and related activities (such as scheduling appointments for the individual and/or locating a provider) to help members obtain needed services, including activities that help the individual gain access to medical, social educational, and other services;***
- ***Providing outreach to members, families, resource providers on at least a monthly basis to engage in care coordination;***
- ***Ensuring each member has an assigned case manager and the member is provided the name and contact information of their assigned case manager;***
- ***Monitoring and follow-up activities to ensure that care plan services are delivered and the evaluating the effectiveness of services;***
- ***Facilitating case conferences and developing multidisciplinary, shared care plans that include crisis/safety plans, as appropriate; and***
- ***Providing policies and procedures to address crisis situations. At a minimum, these policies and procedures should include the following:***
  - ✓ ***Member is unable to be released from hospital due to no private duty nursing staff available;***
  - ✓ ***Personal situation within the home which may change the family's schedule, requiring additional services;***
  - ✓ ***Private duty nursing staff is not delivering the required number of approved private duty nursing units to the member or does not show up to provide services; and/or***
  - ✓ ***Situations related to weather, natural disasters, shut downs, etc.***

e. **General Eligibility and Assessment for CM** – The health plan shall use the enrollment broker's health risk assessment screening information to determine which new members require screening and potential enrollment in CM at the time of enrollment. For all members, the health plan shall use the initial assessment to identify the issues necessary to start the formulation of the member's Care Plan if CM is initiated. The assessment for CM criteria includes:

1) An assessment shall occur within 30 calendar days of health plan enrollment for new members;

   - New members include those who have reenrolled with the health plan after a lapse of ineligibility of more than 60 days;

2) An assessment shall be performed by the health plan for CM and DM within 30 calendar days of a member's new diagnosis of one or more of the following conditions:

   - Diabetes;
   - Obesity;
   - Hypertension;
   - Asthma;
   - Chronic Obstructive Pulmonary Disease (COPD);
   - Attention Deficit/Hyperactivity Disorder (ADHD);
   - Congestive heart failure;
   - Cancer;
   - Chronic pain with opioid dependence;
   - Hepatitis C in active treatment;
   - HIV/AIDS;
   - Sickle Cell Anemia;
   - Organ failure requiring supportive treatment and potentially requiring transplant (e.g., End-Stage Renal Disease (ESRD) and dialysis requirement or pancreatic/hepatic failure);
   - Individuals with special health care needs including those individuals, who, without services such as private duty nursing, home health, durable medical equipment/supplies, or CM may require hospitalization or institutionalization. The following groups of individuals are at high risk of having special health care needs:

     ✓ Individuals with Autism Spectrum Disorder;

     ✓ Individuals with serious mental illness including, at a minimum: schizophrenia, schizoaffective disorder, bipolar disorder, PTSD, major depression, reactive attachment disorder of childhood, disruptive mood dysregulation disorder, oppositional defiant disorder, separation anxiety disorder of childhood and moderate to severe substance use disorder; and

   - Any other condition for which the health plan determines the member would benefit from CM services.

3) For purposes of this document, DM shall be defined as the process of intensively managing a particular disease or syndrome. DM shall encompass all settings of care and shall place a heavy

emphasis on prevention and maintenance. Similar principles shall apply to DM as in CM, but DM shall be more focused on a defined set of goals relative to a disease process. Members with one or more of the following disease conditions shall be eligible to receive DM services:

- Asthma/COPD;
- Depression;
- Obesity;
- Multiple Comorbid Conditions; and
- Any other disease condition for which the health plan determines the member would benefit from DM services.

4) Necessary components specific to DM include, at a minimum, the following:

- The health plan shall offer DM to members as early in the development of the disease state as possible;
- The health plan shall operate its DM programs using an "opt out" methodology, meaning that DM services shall be provided to eligible members unless they specifically ask to be excluded;
- The health plan shall emphasize the prevention of exacerbation and complications of the conditions as evidenced by decreases in emergency room utilization and inpatient hospitalization or improvements in condition-specific health status indicators;
- The health plan shall utilize evidence-based clinical practice guidelines that have been formally adopted by the health plan's Quality Management/Quality Improvement (QM/QI) committee or other clinical committee;
- The health plan shall 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 DM conditions. This includes, at a minimum, 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 provider education shall be designed to increase the providers' adherence to the guidelines in order to improve the members' conditions; and
- 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.

5) CM shall be offered to individuals eligible for Supplemental Security Income (SSI);

6) The health plan shall screen and offer all pregnant members for CM needs. The requirements for contact and specific tasks include:

- The health plan shall offer CM within 15 business days of date effective with the health plan of newly eligible members or within 15 business days of notice of pregnancy for currently eligible members;

- The initial CM and admission encounter shall include an assessment (face-to-face or telephone) of the member's needs and must be completed within 15 business days from the date effective with the health plan for newly eligible members or within 15 business days of notice of pregnancy for currently eligible members;

- 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 Risk Appraisal form. These forms may be obtained from the *Physician Provider Manual* on the state agency's website at: 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 Use Treatment Referral Protocol for Pregnant Women Under the Managed Care Program;

- Referrals to prenatal care (if not already enrolled), within two weeks of enrollment in CM;

- Referral to a dental provider for an annual dental visit (if not already scheduled), within six weeks of enrollment in CM;

- Tracking mechanism for all prenatal and post-partum medical appointments. Follow-up on broken appointments shall be made within one week of the appointment with documentation indicating why the appointment was broken. This information could potentially be used for identifying trends through a root cause analysis process to determine if intervention could improve outcomes;

- Methods to ensure that EPSDT/HCY screens are current if the member is under age 21;

- Referrals to WIC (if not already enrolled), within two weeks of enrollment in CM;

- Assistance in making delivery arrangements by the 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 24 hours of those who are subject to abuse or abandonment;

- Assistance to the mother enrolling the newborn in ongoing primary care (EPSDT/HCY services) including provision of referral/assistance with a Managed Care Program 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;

- Notification to current health care providers when CM services are discontinued and why services are discontinued;

- Referrals for family planning services if requested; and

- Directions and supplemental education to members to start taking folic acid vitamin prior to next pregnancy.

7) The health plan shall demonstrate processes of obtaining notification of lab results pertaining to elevated blood lead levels and offer CM within the following timeframes to all children when knowledge of elevated blood levels is present:

- These action levels include outreach time requirements for CM:

  - ✓ 5 to 9 ug/dL within five to ten (5-10) business days;
  - ✓ 10 to 19 ug/dL within one to three (1-3) business days;
  - ✓ 20 to 44 ug/dL within one to two (1-2) business days;
  - ✓ 45 to 69 ug/dL within twenty four (24) hours; and
  - ✓ 70 ug/dL or greater – immediately.

8) The health plan shall document, in real time, the offering of and all aspects of CM for elevated blood lead levels in the Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC) Lead Application database. The database is a secure application accessible through the following website: https://healthapps.dhss.mo.gov/Login/Login.aspx?ReturnUrl=%2fsmhw. In each entry, the health plan shall include the date on which CM was offered or provided to the member. If outages occur, the state may take into consideration late entries in MOHSAIC on CM as long as original dates are specified within the documented notes.

9) By January 31 and July 31 of every year (bi-annual), the health plan shall submit an attestation verifying all aspects of CM for elevated blood lead levels have been documented in the MOHSAIC database for the previous six months.

10) In addition to the requirements listed above, the health plan shall ensure CM activities include the following services for children with elevated blood lead levels. This includes confirmation of capillary tests using venous blood according to the timeframes listed below:

- 5-9 ug/dL – Within one (1) to three (3) months;
- 10-44 ug/dL – Within one (1) week to one (1) month;
- 45-59 ug/dL – Within forty-eight (48) hours to two (2) weeks;
- 60-69 ug/dL – Within twenty-four (24) to two (2) days; and
- >=70 ug/dL – Urgently as emergency test immediately.

12) Ensure that the Childhood Blood Lead Testing and Follow Up Guidelines are followed as required:

- 5-9 ug/dL - Early follow up testing- Within three months. Later follow up testing after BLL declining within six to nine months;

- 10-19 ug/dL - Early follow up testing-Within one to three months. Later follow up testing after BLL declining three to six months;

- 20-24 ug/dL - Early follow up testing-Within one to three months. Later follow up testing-within one to three months;

- 25-44 ug/dL - Early follow up testing-within two weeks to one month. Later follow up testing one month;

- >=45 ug/dL – Early and later follow up as soon as possible; and

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

13) A minimum of two member/family encounters, face-to-face or video conference. Initial visit must be performed within two weeks of receiving a confirmatory BLL that met the lead CM 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 care manager's name and telephone number.

14) Follow-up visit or second encounter within three 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 shall be performed at that time.

15) An exit evaluation/case closure and education contact shall be performed prior to discharge. This may be done once the labs have normalized and at the time the family is informed of normalization of the lead level. If the child meets the criteria for discharge, this encounter must include, at a minimum, discharge counseling regarding current BLL status, a review of ongoing techniques for prevention of re-exposure to lead hazards, as well as nutrition, hygiene, and environmental maintenance. This contact may occur via telephone, video conference or in person by the care manager.

16) A discharge action may take place on an existing lead case if the health plan has made at least three different types of attempts (home visit, sending letters with an address correction request, checking with the PCP, WIC, and other providers and programs) to contact the member/family to conduct an exit evaluation/case closure. All attempts to contact must be documented in MOHSAIC along with the reason for closure. Notification of the closure must be sent to the member/family with instructions for contacting the health plan to resume care management activities.

17) 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 care manager. The notes must also include the plan of care and include, at a minimum, BLLs, 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 care 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 care 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 care manager, contacts with the child's PCP, and progress made to meet plan of care goals.

- Exit evaluation/case closure contact: 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 assistance and questions, status of plan of care goal completion, member/family and PCP notification of discharge from CM, and a continued care coordination plan.

18) The health plan shall provide an assessment for CM for all members experiencing one of the following:

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

19) The health plan shall conduct such assessments within 30 calendar days of:

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

- The last day of the month following the end of a quarter in which a member has had three or more emergency department visits as identified through analysis of utilization date.

20) The health plan shall assess members for CM within five business days of admission to a psychiatric hospital or residential substance-use treatment program.

f. **Coordination with Primary Care Health Homes and Behavioral Health Homes** – The health plan shall coordinate services for its members who are in Physical Health Homes and Behavioral Health Homes. The health plan must identify any care gaps or areas of duplication through a method mutually acceptable between the health plan and the state agency. The health plan shall be responsible for being the primary source of CM for conditions other than or beyond those included in the state Health Home and Behavioral Health Home programs.

1) The Managed Care Program Primary Care Health Homes shall be responsible for providing CM for the following conditions:

- Cardiovascular disease;
- Chronic pain;
- Asthma/COPD;
- Overweight/Obesity;
- DD;
- Diabetes;
- Tobacco use;
- Depression;
- Anxiety; and
- SUD (when Patient Centered Health Home (PCHH) provider organization has at least one clinical provider certified to provide medication-assisted treatment).

2) DMH's Behavioral Health Homes are responsible for providing care management for the following conditions:

- Serious and persistent mental illness;
- Other mental health conditions;
- SUD; and

- The chronic physical conditions listed in the Primary Care Health Home section above when they are co-occurring in individuals who have serious mental illness, other mental health conditions, and/or SUD.

3) The health plan shall assess members who are enrolled in either Health Home for CM for conditions other than those that are care managed by the health homes.

Addendum 02 added a word to the subparagraph below.

4) The health plan ***shall*** coordinate with a Health Home in the care of a plan member in the Health Home program. The health plan and the Health Home shall communicate on a regular basis as mutually agreed upon by both organizations, for example weekly, month or quarterly. The communication should include sharing of information regarding the member's needs; this should also include Health Home services underway including CM. The CM information should include progress for the condition(s) for which the health home is providing health home services, and transitions of care such as changes in primary care physician, address changes, difficulty or inability to contact participants, or discharge from the health home. In addition, the health plan shall provide support to the Health Home for situations and conditions beyond the scope of the Health Home or for which the Health Home is not designed. Through these activities, the health plan shall work with the Health Home in identifying any gaps in care and any duplication of services.

5) The health plan shall provide coordination with a PCP for members participating in the state agency's Home Health Program.

6) 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.

7) The health plan shall identify a single point of contact for the Section 2703 designated Health Home provider.

8) The health plan shall not provide CM including DM services that duplicate those reimbursed to the Section 2703 designated Health Home. Members may be enrolled in CM by the health plan due to other diseases or conditions that are not being managed by the Health Home.

9) The Health Home shall be responsible for notifying the health plan of gaps in care or additional resource needs (i.e. transportation) for members in a Health Home. The health plan shall assist the Health Home with coordination of services when the health plan is notified of a need that cannot be provided by the Health Home.

10) The health plan shall inform the Health Home of any inpatient admission or discharge of a health Home member within 24 hours.

11) The health plan shall 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.

12) If the member is in CM at the time of discharge from a Health Home, the Health Home is required by their agreement with the Managed Care Program to coordinate the TOC with the health plan to aid in the transition into the health plan's CM program. The health plan is required to work with the Health Home when the member is discharged from the Health Home.

g. **CM Closure** - The health plan shall have criteria for terminating CM services. These criteria shall be included in the care plans. Acceptable reasons for case closure for CM (excluding CM for elevated lead levels) include the following:

1) Achievement of goals stated in the care plan including stabilization of the member's condition, successful links to community support and education, and improved member health;

2) Member request to withdraw from either CM or health plan;

3) Lack of contact with the care manager or lack of compliance with CM. This must be documented in the care plan. At least three different types of attempts shall be made prior to CM closure for this reason. Where appropriate, these should include attempts to contact the member's family. Examples of contact attempts include:

- Making telephone call attempts before, during, and after regular business hours;
- Visiting the family's home; sending letters with an address correction request; and
- Checking with PCP, WIC, and other providers.

4) The health plan shall review cases for closure from prenatal CM no sooner than 60 calendar days from the date of delivery;

5) For all members receiving CM due to elevated BLL, the health plan shall review cases for closure using the following occurrences:

- When current BLL is less than 5 ug/dL; or
- When the member is disenrolled and referral to a new health plan, LPHA, or health care provider has been completed.

6) The PCP must be notified in writing of all instances of member discharge from CM and the reason for discharge. The discharge notification must include a history of member's condition.

7) The health plan shall provide quarterly and yearly outcome measurements and reporting. The reporting requirements specified herein shall satisfy this component.

2.12.2 Hospital Care Transition (HCT) Management:

a. **General Overview** – Members identified through the hospital discharge risk assessment and in need of TOC assistance, shall receive onsite HCT management services upon admission to a hospital, at the discretion of the health plan. The services provided under the HCT program must integrate with and enhance the discharge planning and care transition activities required of the hospital by CMS. The efforts of the health plan must not interfere with or contradict the legitimate efforts of hospital staff to perform their responsibilities. The efforts of all collaborative work must maintain the patient and caregiver goals as the cornerstone of the discharge planning and transition management process, taking into consideration the provider diagnosis, assessment, prognosis, and provider recommendations for post-acute services.

1) The purpose of HCT management services is to bridge the gap between hospital and community, enhance member experience and satisfaction, improve clinical outcomes, and increase the overall value of services provided by the health plan. HCT Coordinators shall collaborate with facility staff responsible for discharge planning to understand the discharge risk assessment, patient and caregiver and goals of care, and provider recommendations. The HCT Coordinators shall assist the member in the transition of members' care by providing education about in-network care providers, programs they may be eligible for, and community-based resources etc. In doing so, HCT Coordinators will abide by facility policies and procedures, and other applicable federal and state laws governing access to patients and secure patient data. This program shall not replace the health plan's existing member CM, DM, or utilization management programs required under a contract(s) awarded in response to this RFP.

2) The goal of this program is to achieve the following outcomes:

- Ensure patient goals of care and medical necessity serve as the basis for discharge planning and TOC services;
- Align and communicate discharge plans that are developed between the patient, responsible caregiver, hospital, and health plan. The discharge plan must be based on the patient's goals of care, medical necessity, quality, and other data available to the patient. The health plan shall be responsible for communicating with the patient and identifying potential in-network care and service providers;
- Reduce administrative burden and prevent unnecessary delay in discharge;
- Reduce avoidable bed days and readmissions, and coordinate referrals to internal programs and community services; and
- Increase communication with PCP, specialty providers, and caregivers regarding admission, discharge, and follow-up care.

b. HCT Coordination and Care – The health plan shall develop a plan with hospitals to facilitate TOC for members, employing the use of HCT Coordinators to engage members at the bedside and provide TOC assistance, as determined by the health plan's Care Management team. The health plan must take the hospital's regulatory requirements and processes into account. HCT Coordinators shall be onsite at the facility, when health plan members are identified with an admission requiring HCT management services, in order to work directly with the hospital staff to assist members in their care transition. Active participation and accommodation by hospitals, in partnership with the HCT Coordinator and health plan, shall be essential to achieve the HCT program quality outcomes and HCT management activities shall be conducted in accordance with hospital policies and procedures to ensure ongoing patient care is not disrupted or compromised. HCT Coordinators will not engage in or interfere with inpatient care treatment plans or regimens and shall not be used by the health plan for utilization review or service authorizations related to inpatient care. Information obtained by the HCT Coordinators will be shared with hospital staff to ensure access to timely and accurate information. Services provided by HCT Coordinators shall include, at a minimum, the following:

1) Obtaining discharge disposition/location, including post-discharge contact information;

2) Collaborating to ensure referral and access to high-quality, in-network secondary level of care (i.e. acute inpatient rehab, long-term acute care hospitals, skilled nursing facilities, behavioral health services, etc.);

3) Coordinating home care services (i.e. home health, home infusion, durable medical equipment, pharmacy, etc.);

4) Coordinating community services (i.e. - transportation, other resources and services to address social determinants, etc.);

5) Providing member benefit education (prescriptions, member concerns, chart/medical history, etc.);

6) Scheduling or validating follow-up appointments with providers as recommended by the hospital attending physician and health plan that are in alignment with the member and caregiver goals;

7) Ensuring the member has an assigned primary care physician;

8) Maintaining continuum of care by helping to ensure connections and communications with post-discharge programs; and

9) Helping members and caregivers understand discharge plans, current medication lists, transfers plans, and instructions.

c. The health plan shall have written policies and procedures that address all HCT requirements herein.

2.12.3 **TOC Management** - TOC shall be required when members are moving from one health plan to another, moving to or from Fee-for-Service, or moving to or from non-traditional settings, (e.g., incarceration, foster care, etc. to a health plan). The health plan must ensure that TOCs occur with minimal service disruption. In an effort to ensure adequate TOC management, the health plan shall provide to the state agency a contact person for TOC inquiries. The health plan shall also designate and share a point of contact to aide in the outreach efforts during transitions between health plans. The health plan shall be in compliance with the requirements stated in a contract(s) awarded in response to this RFP as well as those rules outlined in 42 CFR 438.62 and 42 CFR 438.208. The health plan's responsibilities are as follows and shall be described in the health plan's TOC policies:

a. Provide for the transfer of relevant member information, including medical records and other pertinent data, to another health plan upon notification of transition.

1) If a member enrolls with the health plan from another health plan, the health plan shall, within five 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. If member contact is not successful, the health plan shall reach out to the state for the information within those five business days.

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 new health plan within five business days of receiving the request.

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 business days of becoming aware of the member's transfer and shall share relevant member information and shall provide answers to any other questions pertinent to ensure minimal disruption to member's care.

4) If the health plan receives new members who were previously members in the Fee-For-Service Program, the health plan must contact the member's fee-for-service provider within five 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.

5) 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 transition to the new subcontractor.

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

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 or behavioral health 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 60 calendar days, or until the member has transferred, without disruption of care, to an in-network provider.

2) For members eligible for CM, the new health plan shall provide continuation of services authorized by the prior health plan for up to 60 calendar days after the member's enrollment in the new health plan and shall not reduce services until an assessment supporting services reduction 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 Managed Care Program 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 60 calendar days or until the member has been seen by the assigned PCP 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 60 calendar days from date of birth).

h. Allow pregnant members to continue to receive services from their behavioral health 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 TOC.

2.12.4 Show-Me ECHO (hereinafter referred to as Extension of Community Healthcare Outcomes):

a. The health plan shall participate in Show-Me ECHO using video-conferencing technology to connect teams of interdisciplinary experts with PCPs.

b. The state may audit health plan participation in Show-Me ECHO.

2.13 Eligibility, Enrollment, and Disenrollment Requirements:

2.13.1 The state agency is responsible for eligibility determinations. The state agency will conduct enrollment activities for Managed Care Program eligibles. The health plan or its subcontractors may assist enrollees with applying for Managed Care Program benefits, including assisting mothers of newborns with supplying information to the state agency.

2.13.2 **Enrollment Counseling** – The state agency will operate a toll-free telephone line to make helpline operators available to all Managed Care Program eligibles to provide assistance in selecting and enrolling into a health plan. Helpline operators will also be available by telephone to assist Managed Care Program

eligibles who would like to change health plans. The health plan shall refer Managed Care Program eligibles and members to the toll-free helpline when needed. 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 PCP, the health plan member's right to choose a PCP 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 with the health plan, 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 nay 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 CM, DM, LCCCP, and health home programs. Any baseline health status data will be made available to the health plan. *The Department of Social Services MO HealthNet Managed Care Health Risk Assessment* template is located on the state agency website at: https://dss.mo.gov/business-processes/managed-care-2023/vendor-documents/.

f. Inquiring and recording primary language information;

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

h. Providing a listing of the health plan PCPs generated from the provider demographic electronic file submitted by the health plan to the state agency; and

i. Informing the eligible of the populations excluded from Managed Care and their right to disenroll with and without case.

2.13.3 **Voluntary Selection of Health Plan** – Managed Care Program eligibles will be automatically assigned to a health plan on the date the state agency determines such individuals eligible for the Managed Care Program. Managed Care Program CHIP eligibles, who are required to pay a premium for their coverage, will be automatically assigned to a health plan the date the CHIP payment is posted to their account. Once a member is assigned to a health plan, the member will have 90 calendar days from the initial enrollment effective date to change health plans without cause.

2.13.4 **Automatic Assignment into Health Plans** - The state agency will employ an algorithm to assign members to each health plan, on a prorated basis. The algorithm will be based on the following:

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

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

c. If a health plan has 55% 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 20% of the regional membership or 25,000 members, whichever is greater, that health plan will receive 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 20% of the regional membership or 25,000 members, whichever is greater, 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 20% of the regional membership or 25,000 members, whichever is greater. 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 20% or 25,000 members, whichever is greater, and less than 55% of the membership within each region, the health plans will equally share in the allocation from the auto-assignment process following the application of the algorithm criteria for items a. and b. above.

g. The enrolment 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.

2.13.5 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 PCP should they regain eligibility within 60 calendar days. If more than 60 calendar days have elapsed, the member will be auto-assigned to a health plan and a PCP. The member will have 90 calendar days from the effective date of coverage with the health plan in which to change health plans for any reason.

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.

2.13.6 Health Plan Lock-In:

a. All members will have a 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 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. All transfers between health plans that members request during the first 90 calendar days following initial enrollment shall be granted without review by the state agency. Both the 90-calendar day and the 12-month enrollment period begin on the same day.

2.13.7 Open Enrollment:

a. The state agency will conduct open enrollment for the contract period. The Managed Care Program eligible shall be assigned to the health plan he/she was previously enrolled in if the health plan was a contracted health plan for the previous contract period. The Managed Care Program eligible will be auto-assigned to a health plan if the eligible does not make a selection during open enrollment.

b. If a Managed Care Program eligible was not previously enrolled in a health plan within the last 60 calendar days, the Managed Care Program 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 members 12 month enrollment anniversary date with the health plan. The state agency will provide an open enrollment notice to members at least 60 calendar days before each annual enrollment opportunity.

2.13.8 **Suspension and/or Limits on Enrollment –** The state agency reserves the right to suspend or limit enrollment into a health plan. In the event the health plan's enrollment reaches 55% of the total enrollment in the region, the health plan shall not be offered as a choice for enrollment, nor shall 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 60 calendar 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.

2.13.9 During the open 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.

2.13.10 Health Plan Enrollment Procedures:

a. The health plan shall and implement written policies and procedures for enrolling members within five 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 telephone, or in-person) the member by the following Tuesday).

b. The health plan shall enroll any Managed Care Program eligible that selects the health plan or is assigned to 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 enrollment.

d. The health plan shall make their best effort to conduct an initial screening of each member's needs, within 90 calendar days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the member if unsuccessful.

2.13.11 **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 unless the newborn is placed in state care and custody. 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. 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 if 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.

2.13.12 Enrollment and Disenrollment Process:

a. Daily – Every business day, the state agency will 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 plan's subcontractors' management information system each day.

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

2.13.13 **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 PCP; 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.

2.13.14 **Assignment of PCP** – 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 PCP. The process must include at least the following features:

a. Contact with the member within five 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 PCP selection.

b. At the time of the state agency's notification to the health plan, the health plan shall assign a PCP 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 PCPs name, location, and telephone number, and (2) options for selecting a PCP other than the PCP assigned to the member. The health plan shall inform the member that he/she has 15 calendar days to choose another PCP if they do not approve of the PCP assigned to them, and if they have not notified the health plan of their preferred PCP within that timeframe, the member will remain with the PCP previously assigned to the member.

c. Prior to becoming effective with the health plan, if a member does not select a PCP or the health plan has not already assigned a PCP 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 PCPs name, location, and office telephone number. The member must have a PCP assigned by the time the member is effective with the health plan. If circumstances are such that the member does not have a PCP 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 PCPs to members, during the readiness review and upon request by the state agency.

2.13.15 **Identification Cards**:

a. The state agency will issue an identification card to all Managed Care Program eligibles. This card is not proof of eligibility. The card contains a magnetic strip that is a key for accessing the state agency's electronic eligibility verification systems by Managed Care Program enrolled providers. There will be no health plan specific information printed on the card.

b. The health plan shall issue a membership card that contains information 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 (hereinafter referred to as DCN), PCP 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 as soon as practicable following the member's effective date of coverage with the health plan. The effective date for Managed Care Program eligibles shall be the same day they are determined eligible for Managed Care. 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 15 calendar days from the notification of the enrollment.

2.13.16 **Member Handbook** – The health plan shall provide a member handbook, and other written materials with information on how to access services, to all members within ten business days of being notified of their future enrollment with the health plan. Information shall be considered to be provided if the health plan:

- ✓ Mails a printed copy of the information to the member's mailing address;
- ✓ Provides the information by email after obtaining the member's agreement to receive information via email;
- ✓ Posts the information on the health plan website and advises the member in paper or electronic format that the information is available on the Internet and shares the applicable Internet address, provided that members with disabilities who cannot easily access this information are provided auxiliary aids and services upon request, at no cost; or
- ✓ Provides the information by any other method that may be reasonably be expected to result in the member receiving the information.

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

b. The health plan shall review the member handbook on an annual basis, make revisions as necessary, and document that such review has 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 comply with all changes regarding member handbook content specified by the state agency within the time defined by the state agency.

1) Table of contents;

2) Information about choosing and changing PCPs, types of providers that serve as PCPs (including information in circumstances under which a specialist may serve as a PCP), and the roles and responsibilities of PCPs;

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

4) A listing of members' rights and responsibilities described herein;

5) Appointment procedures and the appointment standards described herein;

6) Notice that the adult member must present the Managed Care Program identification card (or other documentation provided by the state agency demonstrating Managed Care Program), 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) Information on how and where members may access any benefits provided by the state, including how transportation is provided;

9) A description of all available services outside the comprehensive benefit package, including information on where and how members may access benefits not available under the comprehensive benefit package;

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 Managed Care Program;

13) Notice than 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 may obtain such referral;

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

- ✓ The right to file grievances and appeals;
- ✓ The requirement and timeframes for filing grievance or appeal;
- ✓ The availability of assistance in the filing process;
- ✓ The toll-free telephone numbers that a member may use to file a grievance or an appeal by telephone;
- ✓ The procedures for exercising the rights to appeal and request a state fair hearing;
- ✓ That the member may represent himself or use legal counsel, a relative, a friend, or other spokesperson;
- ✓ The fact that, when requested by the member:
  - ➢ Benefits will continue if the member files an appeal or a request for a 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 or state hearing is pending, if the final decision is adverse to the member.
- ✓ The following is information about the member's right to request a state fair hearing:
  - ➢ A member may request a state fair hearing within 120 calendar days from the health plan's notice of appeal resolution; and
  - ➢ The state agency will reach its decisions within the specified timeframes:
    - For standard resolution – Within 90 calendar days from the state agency's receipt of a state fair hearing request.
    - For expedited resolution – Within three business days from the state agency's receipt of a state fair 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 process.

22) How to report suspected fraud, waste, and abuse activities including the Medicaid Fraud Control Unit (hereinafter referred to as MFCU) fraud, waste, and abuse hotline telephone number;

23) Information about the CM program to include that the member may request to be screened for CM at any time;

24) Information about the DM program;

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 hardcopy 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: (1) What constitutes an emergency medical condition, emergency services, and post-stabilization services; (2) the fact that prior authorization is not required for emergency services; (3) the process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; (4) the locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered herein; (5) the fact that the member has a right to use any hospital or other setting for emergency care; and (6) the post-stabilization care services rules specified herein; and

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

29) Information on EPSDT services including immunization and BLL testing guidelines designated by the state agency;

30) Information on maternity, family planning, and sexually transmitted disease services. This information should include the extent to which, and how, members may obtain family planning services and supplies from out-of-network providers. This information should also include an explanation that the health plan cannot require a member to obtain a referral before choosing a family planning provider;

31) Information on behavioral health 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 telephone 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 when needing after-hours services;

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 the health care provider with a contractual referral, or other type of 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 of arrangement with the health plan in excess of the total 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 tort, or product liability, 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, al prepayment requirements must be met as specified by the other health insurance policy and that the member must notify the health plan of any changes to their other health insurance policy. The member shall be directed to contact the health plan with any questions;

37) Information on the Health Insurance Premium Payment (hereinafter referred to as HIPP) program, which pays for health insurance for members when it's determined cost effective;

38) Information on contributions the member may make towards his or her own health. Appropriate or 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 translator written information, how to access these items and services, and a statement that there is no cost to the member for these items and services;

40) Information on how to access auxiliary aids and services, including additional information in alternative formats or languages;

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

42) 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 shall annually disclose to members, their right to adequate and timely information related to physician incentives;

43) With respect to advance directives, language describing such shall include the following:

- ✓ The member's rights under state and federal law to exercise an advance directive;
- ✓ 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 non-compliance with the advance directive requirements may be filed with the state survey and certification agency, DHSS.

44) 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;

45) A statement that the member has the right to obtain one free copy of his or her medical records and how to make the request for such;

46) Information on how to request and obtain an Explanation of Benefits (hereinafter referred to EOB); and

47) In the event of a counseling or referral service that the health plan does not cover because of moral or religious objections, the health plan must inform members that the service is not covered by the health plan, and the health plan must inform members how they may obtain information from the state agency on how they may access services.

48) A glossary to include all definitions for Managed Care terminology as required in CFR 438.10(c)(4)(i), as amended.

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 directed by the state agency to comply with member handbook requirements.

2.13.17 **Provider Directory** – The health plan shall make available a paper provider directory. In addition, the health plan shall make available, on its website, an up-to-date searchable provider directory.

a. Information included in a paper provider directory must be updated at least quarterly and electronic provider directories must be updated no later than 30 calendar days after the health plan receives updated provider information. The provider directory must include each of the following provider types: physicians, including specialists, hospitals, and behavioral health providers. In addition, the provider directory shall include the names, group affiliations, specialty type, telephone numbers, service site address(es), web site URL, panel status (accepting new patients or not accepting new patients), the provider's cultural and linguistic capabilities including languages (including American Sign Language) offered by the provider or a skilled interpreter at the provider's office. For physicians, this listing shall also include board certification status. Listed addresses shall only include locations where the provider physically practices or is available by Telehealth and sees patients at least one day monthly. Listings shall include where the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment. The health plan shall notify all members 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 48 hours of a member request for a hard copy version of the provider directory.

b. Provider Directory Completeness and Accuracy:

1) The provider directory on the health plan's website shall be accurate and complete. PCPs and psychiatrists must be accepting new members.

- The provider directory shall be evaluated using a secret shopper survey completed on a sample set of providers in each region on an annual basis.

- All findings from a secret shopper survey are subject to inclusion in the state's quality rating score of the health plan.

- During any period, a health plan shall be subject to a corrective action plan (hereinafter referred to as CAP) for not meeting the website accuracy requirement. Provider name, address, telephone number, and the acceptance rate of new members will be evaluated to determine compliance.

2) If the provider directory performance requirements are not met, the health plan shall be required to submit a CAP. The CAP must address performance issues; identify improvement opportunities and goals, and describe actions to improve performance. The CAP shall also include the health plan's periodic performance monitoring process to evaluate progress. The CAP shall be subject to state agency's approval. The health plan shall maintain documentation demonstrating compliance with the CAP. Such documentation shall be subject to audit by the state agency at any time. Any non-compliance by the health plan in its execution of the CAP may result in liquidated damages. Portions of the CAP not implemented by the health plan or not resulting in the approved goal(s) detailed in the plan of action may be subject to liquidated damages.

3) The state agency will monitor and assess the accuracy of the provider directory on the health plan's website relative to dentists.

2.13.18 Disenrollment:

a. The state agency will monitor, and approve or disapprove all transfer requests for just cause, within 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 90 calendar days of initial enrollment, or for just cause;

2) 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;

3) Loss of eligibility for either the Fee-For-Service Program or the Managed Care Program; or

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

b. Member Requests – A member may request to disenroll from a health plan for reasons that include, at a minimum, the following:

1) Member requests health plan transfer during open enrollment;

2) Member requests health plan transfer during the first 90 calendar days enrolled in a health plan;

3) Just cause reasons that include:

- Transfer is the resolution to a grievance or appeal;

- PCP 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 PCP or obstetrician does not participate in the health plan but does participate in another health plan;

- Member is a newborn and the PCP 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;

- A health plan does not cover the services the member seeks because or moral or religious objections;

- Other reasons including, at a minimum, 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;
- A transfer is requested so that all family members are enrolled in the same health plan; and
- A transfer is requested when the state imposes sanctions on a health plan for non-performance of contract requirements.

Addendum 02 deleted the subparagraph below.

c. DELETED.

d. Health Plan Requests:

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

- 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 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 disenroll the member; and
- 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 interventions over a period of 90 calendar days which occurred through treatment, member education, coordination of services, and CM to resolve any difficulty leading to the request, unless the member has demonstrated abusive or threatening behavior in which case only one attempt is required. The health plan shall cite at least one 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 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 30 calendar days before the end of the 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 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 15 business 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 will consider the health plan to have breached the provisions and requirements of the contract and the health plan 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 and shall be no later than the first day of the second month following the month in which the enrollee or the health plan files the request. The disenrollment request shall be approved if the state fails to make the disenrollment determination within the specified timeframes. 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 participating in the 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 Fee-For-Service Program or Managed Care Program eligible or opts out of participating.

2) For the purposes 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 Fee-For-Service Program to Managed Care Program. 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 Managed Care Program.

2.14 Managed Care Marketing and Member Education Requirements:

2.14.1 **Marketing Plan** – The health plan shall submit a marketing plan to the state agency. At a minimum, the marketing plan shall include the following:

a. A statement ensuring compliance with state and federal regulations, as amended, and with all current and future marketing materials;
b. Outreach activities;
c. Provider relations;
d. Subcontractor compliance;
e. Direct member communications;
f. Ongoing compliance monitoring; and
g. Internal processes (i.e. staff hierarchy).

2.14.2 **Attestation** – At least once annually, the health plan shall submit a Marketing Materials Attestation indicating that the marketing plan and materials referenced or used within the attestation period meet all state, federal, and contract requirements, are true and accurate, and have been reviewed by the health plan. The Marketing Materials Attestation shall include, at a minimum, the following:

a. Marketing plan name;
b. Attestation submission date;
c. Attestation period (previous FY – July 1 – June 30);
d. Signatures of Compliance Officer and CEO;
e. Attestation statement;
f. Listing of each marketing or member education material(s) to include:
    1) Tracking number;
    2) Document title/name;
    3) Date of submission; and
    4) Date of final revision.

2.14.3 **Marketing and Member Education Requirements** - The health plan shall educate Managed Care Program members, subject to the restrictions and definitions outlined herein. Education activities efforts shall be directed to current members to provide knowledge or skills. The health plan may conduct marketing activities for Managed Care Program members. Marketing campaigns shall be efforts directed to an audience of members and potential health plan members to retain or increase health plan membership.

a. The health plan shall comply with all state and federal regulations, as amended, to include, at a minimum, 42 CFR 438.10, 438.100, and 438.104.

b. The health plan shall submit all marketing and member education materials to the state agency as specified herein. The health plan shall be responsible for submitting materials from subcontractors, in-network providers, vendors, etc.

    1) The health plan shall be responsible for tracking all marketing and member education materials submitted to the state agency according to the guidance provided in the Marketing Guidance located and periodically updated on the state agency website.

    2) The health plan shall submit all materials in camera-ready format, specific to the Managed Care Program.

    3) When submitting marketing and education material(s), the health plan shall indicate how and when the material(s) will be used, the timeframe(s) for the use, and the media to be used for distribution.

    4) The state agency will deem material(s) as conditionally approved on the date of receipt and will not provide a written approval, unless otherwise notified by the state agency.

    5) If the health plan decides to withdraw a submission, the state agency will deem the material(s) withdrawn on the date of health plan request and will not provide a written confirmation of withdrawal.

    6) All health plan marketing and member education materials are subject to state agency audit at any time, at the discretion of the state agency.

c. The health plan shall obtain prior approval on member notice templates as directed by the state agency.

d. The health plan shall market and distribute their marketing and member education materials on a statewide basis. The health plan shall only distribute materials in compliance with their contract. The

health plan shall supply current materials and shall remove their outdated materials from public areas as necessary.

e. The health plan shall ensure that in-network providers provide equal representation of all 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 ensure the following of the health plan sponsors or participates in community activities, programs, or events including at provider sites:

1) For purposes of this document, community activities are defined as activities where people come together to learn or ask questions about health care benefits, responsibilities, and procedures. At community activities, the health plan shall only use marketing materials submitted and approved by the state agency and must adhere to the ban on engaging in enrollment activities required herein.

2) The health plan may offer the availability of gifts of no greater than $15 in value, and only if such gifts (promotional items) are offered during any community activity (e.g. health fair). The nominal gift must be offered to all individuals attending the community activity. The health plan shall follow all guidelines outlined by the OIG in relation to nominal gifts. 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.). Gifts must include written proof of cost per unit when submitted for approval. Gifts do not have to be re-submitted to the state agency for additional community activities. Advertising the availability of gifts through mailings, TV or radio, social media, posters, or other promotions or publicity shall be prohibited.

g. The health plan and its subcontractors shall make the general public aware of the Managed Care Program by providing any of the following:

1) General Managed Care Program eligibility information;
2) Managed Care Program applications to complete and mail; and
3) Links to web applications.

2.14.4 Prohibited Activities – The health plan shall not participate in the following activities in addition to the requirements outlined in 42 CFR 438.104.

a. Use of any report, graph, chart, picture, or other document produced and included in whole or in part under the Managed Care Program or contract that is subject to copyright or the subject of any application for copyright on or behalf of the health plans.

b. Offer raffles or conduct lotteries. Door prizes may be offered within the parameters and limits specified for participation in community activities, programs, or events.

c. 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.

d. Use of testimonial materials or celebrity endorsements of the health plan as an enrollment inducement.

e. May not verbally, or in writing, portray a covered benefit as enhanced, additional, or extra.

2.14.5 State Audit:

a. The state agency may select a sample of submitted marketing and/or member education materials for an audit on a periodic basis. Non-compliance by the health plan may result in denied use of the materials and other actions as noted elsewhere herein.

b. The health plan shall correct problems and errors in marketing or member education materials identified by the state agency. The health plan shall submit to the state agency, any corrected materials within 15 business days following the receipt date of the written notice from the state agency with the request for corrections to problems/errors. Non-compliance by the health plan may result in denied use of the materials and other actions as noted elsewhere herein.

c. The health plan shall 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 a listing of what constitutes approved materials to in-network providers including the following:

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 the Managed Care Program, informing such recipients of all health plan(s) with which the provider has contracted;
3) A display of all contracted health plan(s) providing marketing and health education materials in equal fashion;
4) A listing of all contracted health plan(s) telephone numbers; and
5) A display of the enrollment helpline telephone number.

d. The health plan shall not submit provider-facing materials to the state agency. Provider-facing materials will be coordinated between the health plan and the provider.

e. If the health plan is new to the Managed Care Program, the state agency will supply the health plan with a list of marketing and member education materials, in order of priority, for expedient review immediately following the state agency's notification to the health plan to proceed with contract services.

2.15 **Member Services Requirements –** 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.

2.15.1 **Member Services Staff** - The health plan shall provide adequately trained member services staff to operate at least nine 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. Central Standard Time), 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 PCP;

b. Educating the family about Managed Care, including the way services typically are accessed under Managed Care and the role of the PCP;

c. Specifying the member's rights and responsibilities;

d. Explaining covered benefits;

e. Assisting members to make appointments and obtain services;

f. Arranging medically necessary transportation for eligible members;

g. Handling, recording, and tracking member inquiries promptly and timely;

h. Assisting in changing PCPs;

i. Providing the following information to members requesting the names or providers:

1) Whether the provider currently participates in the health plan;

2) Whether the provider is currently accepting new patients; and

3) Whether there are 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; and

k. Referring members to community and social supports.

2.15.2 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 services 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, other clinician, or a 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 24 hours a day, seven 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 24 hours a day, seven days per week behavioral health crisis line that is staffed by Qualified Behavioral Healthcare Professionals (QBHP). 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 use different telephone numbers. If the same number is used for all lines, the call prompts shall be clear to ensure that members reach the appropriate individual.

e. All toll-free telephone lines/call centers shall meet, at a minimum, the following call center standards:

1) 90% of calls shall be answered within 30 seconds;
2) The call abandonment rate shall be five percent or less;
3) The average hold time shall be two minutes or less; and
4) The blocked call rate shall not exceed one percent.

f. All toll-free telephone lines/call centers shall provide 24 hours per day telecommunications services, American Sign Language 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 plan 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 to the state agency in an accessible format upon request.

2.15.3 **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 may be either hard copy or electronic.

2.15.4 **Interpreter Services** – The health plan shall make interpreter services available to potential enrollees and require the health plan make those services available free of charge to each member. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that the state identifies as prevalent.

2.15.5 **Internet Presence/Website** – The health plan shall have a member portal in its website that is available to all members and which contains accurate, up-to-date information about the health plan, services provided, the provider network, FAQs, and contact telephone numbers and e-mail addresses. The section of the health plan's website relating to the Managed Care Program 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. The health plan shall inform all members that the information is available in paper form without charge upon request and provides it upon request within five calendar days.

2.15.6 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 (e.g., large print, Braille, cassette, and diskette) immediately upon request from members with sensory impairments. Auxiliary aids and services must also be made available upon request of the potential enrollee or enrollee, at no cost. The health plan shall develop appropriate methods for communicating with visual and hearing-impaired members and accommodating the physically disabled.

b. The health plan shall make its written materials that are critical to obtaining services including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices available, in the prevalent non-English languages, in its particular service area. Written materials must also be made available in alternative formats upon request of the potential enrollee or enrollee, at no cost. Language assistance to potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English shall also be provided. Written materials must include taglines in the prevalent non-English languages in the state, as well as in a conspicuously visible font size, explaining the availability of written translation or oral interpretation to understand the information provided, how members may request auxiliary aids and services and the toll-free and TTY/TDY telephone number of the health plan. You may find the top 15 languages spoken by individuals with limited English proficiency identified for the state of Missouri at: https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/top15-languages/index.html?languages. The health plan shall make available general services and materials, such as the health plan's member handbook, in those languages. 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 grade reading level. Suggested reference materials to determine whether this requirement is being met include the following:

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 provide all written materials for potential enrollees and enrollees consistent with the following:

1) Use easily understood language and format;
2) Use a font size no smaller than 12 point;
3) Be available in an alternative format and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of potential enrollees or enrollees with disabilities or limited English proficiency; and
4) Include a conspicuously visible font size tagline and information on how to request auxiliary aids and services, including the provision of materials in alternative formats.

e. The health plan shall provide a translation certificate of accuracy with all marketing and member education materials that is in a language other than English.

f. The health plan shall:

1) Submit all materials to the state agency before being distributed.

2) 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.

3) Show the tracking number and the date of the state agency submission in the lower right-hand corner of all materials developed and printed by the health plan.

4) Use mandatory education, marketing, and member notice language provided by the state agency.

5) Maintain a member's right to confidentiality. In particular, post cards must be folded to protect the confidentiality of the member.

6) Ensure additional health benefits are not portrayed as a comprehensive benefit in marketing and member education.

7) Ensure text message communications include an option to opt out and a rate disclaimer.

2.15.7 **Identity Verification** – The health plan shall verify the identity of the member from whom the health plan has received a communication prior to providing benefit related information. Acceptable verification shall include at a minimum of three of the following: name, date of birth, the state agency (Medicaid) number, social security number, or full address**.**

2.15.8 **Changing PCPs** – The health plan shall have and implement written policies and procedures for allowing members to select or be assigned to a new PCP 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 such changes per year; children in COA 4 may change PCPs at will. The health plan shall inform members of the process for initiating PCP changes. Possible reasons for a member to change PCPs shall include, at a minimum, the following:

a. Accessibility – transportation problems, office hours, provider does not return telephone 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 PCP change and a second opinion;

d. Enrollment - PCP with whom the member has an established patient/provider relationship no longer participates in the health plan. In cases where the PCP no longer participates, the health plan shall allow members to select another PCP or make a re-assignment within 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; or

f. Resolution of Grievance or Appeal Process – a PCP change is ordered as part of the resolution to the grievance and appeal process. A member's right to request a change in a PCP through the grievance and appeal process or other means shall not be restricted.

2.15.9 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 the following:

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 shall address the member's responsibilities for the following:

1) Providing, to the extent possible, information needed by providers in caring for the member;
2) How members contact their PCP as their first point of contact when needing medical care;

3) How members follow appointment scheduling processes; and
4) How members follow instructions and guidelines given by providers.

2.15.10 **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.

2.15.11 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 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 new behavioral health subcontractor or other major subcontractor. Notification shall be provided to all members.

2) In-network PCP moves from one in-network clinic or physician group to another. Notification shall be provided to the affected members, seen on a regular basis, within 15 calendar days of the receipt of the move notice. The health plan must notify affected members of the PCPs new location and telephone number. The member must receive new identification cards with the PCPs name and telephone number.

3) Comprehensive benefit package changes from what is explained in the member handbook. Notification shall be provided to all members.

4) Utilization management procedure(s) changes from what is explained in the member handbook. Notification shall be provided to all members.

5) Prior authorization procedure(s) changes from what is explained in the member handbook. Notification shall be provided to all members.

6) Advance directive policy changes as a result in changes in state law. Notification shall be provided 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 defined by the state agency.

2.16 **Member Grievance System Requirements –** 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.

2.16.1 For purposes of the health plan's member grievance and appeals system, the following definitions shall apply:

a. Adverse Benefit Determination:

1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

2) The reduction, suspension, or termination of a previously authorized service;

3) The denial, in whole or part, of clean claims for a service;

4) The failure to provide services in a timely manner as defined in the appointment standards described herein and state requirements specified at 20 CSR 400-7.095, Exhibit A;

5) The failure of the health plan to act within the timeframes provided herein regarding the standard resolution of grievances;

6) The denial of a member's request to exercise his or her right under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network; and

7) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

b. **Appeal** – A review by a health plan of an adverse benefit determination.

c. **Appeal Resolution** – The written determination concerning an appeal.

d. **Grievance** – An expression of dissatisfaction about any matter other than an adverse benefit determination. Possible subjects for grievances include, at a minimum, 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. Grievances includes a member's right to dispute an extension of time proposed by the health plan to make an authorization decision.

e. **Grievance and Appeal System** – The processes the health plan implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

f. **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.

g. **State Fair Hearing** – The processes set forth at herein and in Subpart E of 42 CFR part 431 (as amended).

2.16.2 **Grievance and Appeal System** – The health plan shall have in place, a written grievance and appeal system for members, which defines their rights regarding disputed matters with the health plan. The health plan's grievance and appeal system shall include a grievance and appeals process and access to the state's Fair Hearing process as otherwise specified herein.

a. The health plan shall develop and implement written policies and procedures that detail the operation of the grievance system and provide simplified instructions on how to file a grievance or appeal and how to request a state fair hearing.

b. The policies and procedures must be approved by the state agency prior to implementation and shall be compliant with Subpart F of 42 CFR part 438 (as amended).

c. The policies and procedures shall be approved by the health plan's governing body and shall be the direct responsibility of the governing body.

d. The policies and procedures shall identify specific individuals who have authority to administer the grievance and appeal system policies.

e. The health plan shall distribute to members upon enrollment, a flyer explaining the grievance and appeal system. The 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 may be distributed with the member handbook, but it must be a stand-alone document. The grievance and appeal 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 or grievance dispositions and appeal resolutions. The education material related to grievance and appeals shall be subject to a compliance audit at the discretion of the state agency.

f. The health plan shall also distribute the information on the grievance and appeal system to in-network providers at the time they enter into a contract with the health plan and to out-of-network providers within ten 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 provider, or the grievance and appeal system policies and procedures.

g. As part of the grievance and appeal system, the health plan shall ensure that health plan executives with the authority to require corrective action are involved in the grievance and appeal process.

h. 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.

i. The health plan shall probe inquiries to validate the possibility of any inquiry actually being a grievance or appeal. The health plan shall identify any inquiry pattern.

j. The state agency will maintain an independent state fair hearing process as required by federal law and regulation, as amended. The state fair hearing process will provide members with an opportunity for a state fair hearing before an impartial hearing officer.

k. A member may request a state fair hearing no later than 120 calendar days from the date an adverse benefit determination is upheld through the health plan's internal level of appeal and not resolved wholly in favor of the member. If the health plan fails to adhere to the notice and timing requirements as otherwise specified herein, the member shall be deemed to have exhausted the health plan's internal level of appeal and may initiate a state fair hearing.

l. The parties to the state fair hearing shall include the health plan, the member, and his or her representative or the representative of a deceased member's estate.

m. The health plan shall comply with the decisions reached as a result of the state fair hearing process within 72 hours from receipt of the state fair hearing resolution notice.

n. Health plan members shall have the right to request information regarding the following:

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 using 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 adverse benefit determination;

5) The individual's right to request a state fair hearing, or in the case of an adverse benefit determination based on a change in law, the circumstances under which a hearing will be granted; and

6) The right to request a state fair hearing within 120 calendar days from the health plan's notice of resolution of an appeal.

o. The state will reach its decisions within the following specified timeframes:

1) Standard resolution – within 90 calendar days from the state agency's receipt of a state fair hearing request.

2) Expedited resolution – within three business days from the state agency's receipt of a state fair 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.

2.16.3 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 and appeals, whether received verbally or in writing. At a minimum, the records must contain the following:

1) A general description of the reason for a grievance or appeal;
2) The date the grievance or appeal received;
3) The date of each review or, if applicable, review meeting;
4) The resolution at each level, if applicable;
5) The date of resolution at each level, if applicable; and
6) The name of the member for whom the grievance or appeal was filed.

c. The record must be accurately maintained in a manner accessible to the state and available to CMS upon request.

d. If the health plan does not have a separate log for Managed Care Program members, the log shall distinguish Managed Care Program members from other health plan members.

e. The health plan shall submit the log sheets for all inquiries, grievances, and appeals to the state agency monthly and upon request. Please see *the* Grievance and Appeal Report: Member Issues Log located and periodically updated on the state agency website under Reporting Schedule and Templates.

f. The health plan shall retain member grievance and appeal records for a period of no less than ten years.

Addendum 03 revised the subparagraph below.

g. The state agency may ***publicly*** disclose summary information regarding the nature of grievances and appeals and related dispositions or resolutions in consumer information materials.

2.16.4 Adverse Benefit Determination Notice Requirements:

a. The health plan must give members timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in 42 CFR §438.10.

b. The health plan's notice must explain the following:

1) The adverse benefit determination the health plan has taken or intends to take;

2) The reasons for the adverse benefit determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits;

3) The right of the member to file an appeal or upon written consent, a member's authorized representative or provider may file an appeal on the member's behalf;

4) The member's right to request an appeal of the health plan's adverse benefit determination including information on exhausting the health plan's one level of appeal as described in 42 CFR 438.402(c).

5) The member's right to request a state fair hearing after receiving notice that an adverse benefit determination is upheld;

6) The procedures for exercising the rights to appeal and request a state fair hearing;

7) The member's right to represent himself or use legal counsel, a relative, a friend, or other spokesperson;

8) The specific regulations that support or the change in federal or state law that requires the adverse benefit determination;

9) The circumstances under which an appeal process may be expedited and how to request it;

10) The member's right to and procedures for having 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; and

11) The member's right to receive written notice of extension of 14 additional calendar days for service authorization notices, the reason for the extension, and the member's right to file a grievance if the member disagrees with the decision.

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, the notice shall be mailed at least ten calendar days before the date of adverse benefit determination.

However, the health plan may mail a notice no later than the date of adverse benefit determination under the following circumstances:

- The health plan has factual information confirming the death of a member;
- The health plan received a clear, written statement signed by the member that he or she no longer wishes services or the member 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 calendar days before date of adverse benefit determination if the health plan has facts indicating that adverse benefit determination 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 or she is ineligible for further services; and/or
- The member has been accepted for Managed Care Program services by another local jurisdiction.

2) For denials of claim decisions, at the time of any action affecting the claim.

3) For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 C.F.R. §438.210(d)(1).

- If the health plan meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with 42 C.F.R. §438.210(d)(1)(ii), the health plan must complete the following:
  - Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and
  - Issue and carry out its determination as expeditiously as the member's health condition requires and by no later than the date the extension expires.

4) For service authorization decisions not reached within the required timeframes, the notice of adverse benefit determination must be mailed by the date the timeframe expires.

5) Expedited service authorization decisions must happen within the timeframes specified in 42 C.F.R. §438.210(d)(2).

2.16.5 Grievance Requirements:

a. A member may file a grievance at any time with either the state agency or the health plan. The grievance may be filed 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 related to a grievance. This includes, at a minimum, providing auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate TTY/TTD, American Sign Language, providing interpreter and American Sign Language services.

c. The health plan shall acknowledge receipt of each grievance in writing within ten calendar days after receiving a grievance.

d. The health plan shall ensure that the individuals who make decisions on grievance are individuals:

1) Who were neither involved in any previous level of review or decision-making, nor were a subordinate of any such individual.

2) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the state agency, in treating the member's condition or disease.

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

3) Who takes into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

e. The health plan shall resolve each grievance and provide written notice of the resolution of the grievance as expeditiously as the member's health condition requires, but not more than 30 calendar days past the filing date.

f. The health plan may extend the timeframe for resolution of a grievance for up to 14 additional calendar days if:

1) The member requests an extension; or

2) The health plan demonstrates (to the satisfaction of the state agency, upon the state agency's request), that there is need for additional information and how the delay is in the member's interest.

g. If the health plan extends the timeframe not at the request of the member, the health plan must complete the following:

1) Make reasonable efforts to give the member prompt oral notice of the delay.

2) Within two calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

3) Resolve the grievance as expeditiously as the member's health condition requires and no later than the date the extension requires.

2.16.6 Appeal Requirements:

a. The health plan shall have only one level of appeal for members.

b. If the health plan fails to adhere to the notice and timing requirements stated herein, the member shall be deemed to have exhausted the health plan's internal level of appeal and may initiate a state fair hearing.

c. A provider or an authorized representative may request an appeal on behalf of a member with the member's written consent, with the exception that providers cannot request continuation of benefits as specified in 42 C.F.R. §438.420(b)(5).

d. The health plan shall provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal).

e. The health plan shall include as parties to the appeal, the member and his or her representative or the legal representative of a deceased member's estate.

f. The health plan shall provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The health plan shall inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 C.F.R. §438.408(b) and (c) in the case of expedited resolution.

g. The health plan shall provide the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the health plan (or at the direction of the health plan) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as otherwise specified herein.

h. The health plan shall give members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, at a minimum, providing auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate TTY/TTD, and providing interpreter and American Sign Language services.

i. Following receipt of a notification of an adverse benefit determination by the health plan, a member has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the health plan.

j. The health plan shall acknowledge receipt of each appeal in writing within ten calendar days after receiving an appeal.

k. The health plan shall ensure that the individuals who make decisions on appeals are individuals:

1) Who were neither involved in any previous level of review or decision-making, nor were a subordinate of any such individual.

2) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the state agency, in treating the member's condition or disease.

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

3) Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

l. 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 not more than 30 calendar days past the date of filing.

m. 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, physical or mental health, or ability to attain, maintain, or regain maximum function. The health plan shall ensure that the punitive action is neither taken against a provider who requests an expedited resolution or supports a member's appeal.

n. For expedited resolution of an appeal and notice to affected parties, the health plan has no longer than 72 hours after the health plan receives the appeal. For notice of an expedited resolution, the health plan shall also make a reasonable effort to provide oral notice.

o. The health plan may extend the timeframe for resolution of an appeal for up to 14 calendar days if:

1) The member requests an extension; or

2) The health plan demonstrates (to the satisfaction of the state agency, upon the state agency's request) that there is need for additional information and how the delay is in the member's interest.

p. If the health plan extends the timeframe not at the request of the member, it must complete the following:

1) Make reasonable efforts to give the member prompt oral notice of the delay.

2) Within two calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagree with that decision.

3) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

q. The health plan shall, for all appeals, provide written notice of resolutions in a format and language that at a minimum, meets the standards described at 42 C.F.R. §438.10.

r. The written notice of the appeal resolution must include the following:

1) The results of the resolution process and the date the resolution 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 to 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 adverse benefit determination.

s. Continuation of benefits while the health plan appeal and state fair hearing are pending.

1) As used in this section, "timely files" means for continuation of benefits on or before the later of the following:

- Within ten calendar days of the health plan mailing the notice of adverse benefit determination; or

- The intended effective date of the health plan's proposed adverse benefit determination.

2) The health plan shall continue the member's benefits if the member or the provider timely files the appeal; 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 authorization has not expired; and the member requests continuation of the benefits.

3) If at a 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 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 calendar day timeframe, has requested a state fair hearing with continuation of benefits until a state fair hearing decision is reached; or

- A state fair hearing officer issues a hearing decision adverse to the member.

4) If the final resolution of the appeal is adverse to the member, and 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 services were furnished solely because of the requirements of this section.

t. 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, but no later than 72 hours from the date it receives notice reversing the determination.

u. 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, in accordance with state agency policy and regulations.

2.17 **Provider Services Requirements –** The health plan shall provide all provider services described herein. The health plan shall have and implement provider services policies and procedures that address all provider services activities.

2.17.1 **Provider Services Staff** – The health plan shall provide adequately trained provider services staff to operate at least nine 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. Central Standard Time), 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 PCP assignment;

b. Educating providers on the above mechanisms use;

c. Educating and assisting providers with the health plan service accessibility standards including, at a minimum, 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, family planning, and public health services;

f. Educating providers about how a member may access emergency care and after-hours services;

g. Handling provider inquiries and complaints; and

h. Serving as a liaison between the health plan and the in-network providers and communicating, at least quarterly with in-network providers, including oversight of provider education, in-service training, and orientation. Newsletters, websites, and other media may be used to meet this requirement.

2.17.2 Provider Telephone Lines/Call Center:

a. The health plan shall maintain a toll-free provider services telephone line to respond to provider questions, comments, and inquiries. During non-business hours when the provider services telephone 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. The health plan's provider call center shall have second tier support for questions related to claims, billing, payment and service authorizations that cannot be addressed immediately by the call center representatives.

b. The health plan shall operate a 24 hour, seven days a week toll-free telephone line to provide prior authorizations and confirmations of member enrollment. Recorded messages are not acceptable for this hotline. The number for this telephone line may be the same as the number for the provider services telephone 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) 90 % of all calls shall be answered within 30 seconds;
2) Call abandonment rate shall be 5% or less;
3) Average hold time shall be two minutes or less; and
4) Blocked call rate shall not exceed 1%.

2.17.3 **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, at a minimum, the provider manual, updated 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.

2.17.4 **Provider Manual** – 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 provide notice of changes in policy to providers at least 12 weeks in advance of the planned effective date of the change.

1) A change in the health plan's interpretation of an existing policy shall be construed to be a change in policy requiring advance notice as specified herein.

c. 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.

d. 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 state agency Managed Care Program member, requesting and inspecting the adult member's Managed Care Program identification card (or other documentation provided by the state agency demonstrating Managed Care Program eligibility) and health plan membership card before providing non-emergency services to an adult Managed Care Program member. If the adult member does not 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) PCP responsibilities described herein, including the role of the PCP in CM;

6) Specialist/ancillary provider responsibilities;

7) Information on the provider complaint process, appeal process, and state provider appeal process including:

- The right to file complaints and appeals;
- The requirement and timeframes for filing a complaint or appeal;
- Timeframes to acknowledge and resolve a complaint or appeal;
- The availability of health plan assistance in the provider appeal filing process;
- The procedures for exercising the rights to file an appeal, request a state provider appeal, or file a petition with the Administrative Hearing Commission;
- Citation to the specific regulations that support (or the change in federal or state law that requires) the action; and
- Information about the provider's right to request a state provider appeal is specified elsewhere herein.

8) Information of the member grievance and appeal system including:

- The member's right to file grievances and appeals and their requirements and timeframe for filing;
- The availability of assistance in filing;
- The toll-free telephone numbers to file oral grievances and appeals;
- The member's right to request continuation of benefits during an appeal and state fair hearing and, if the health plan's adverse benefit determination is upheld in a hearing, how the member may be liable for the cost of any continued benefits;
- The member's right to a state fair hearing, how to obtain a hearing, and representation rules at a hearing;

- How the member may request a state fair hearing within 120 calendar says from the health plan's notice of resolution of the appeal;
- The state will reach its decisions with the specified timeframes:
  - ✓ Standard resolution – Within 90 calendar days from the state agency's receipt of a state fair hearing request.
  - ✓ Expedited resolution – Within three business days from the state agency's receipt of a state fair hearing request.
    - ➢ 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 plans expedited appeal timeframes.

9) Procedures for obtaining member eligibility status;

10) Appointment/Service Accessibility Standards;

11) Multilingual and TDD availability and American Sign Language services;

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 provision of MFCU fraud and abuse hotline telephone number.

e. The health plan may be required to amend the provider manual once the LCCCP program application and program are approved by the state agency.

2.17.5 **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 and periodically updated on the state agency website at Health Plan Reporting Schedule and Templates: http://dss.mo.gov/business-processes/managed-care-2017/health-plan-reporting-schedules-templates/. Templates shall include the: address, Social Security Number, Employer Identification Number, date of birth, provider type, Missouri license number or appropriate state license number, National Provider Identifier (NPI, if available), and Office of Inspector General (OIG) exclusion status, exclusion type (if applicable), date of exclusion (if applicable), and date exclusion ends (if applicable). Following the effective date of notification from the state agency to proceed with services, 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 and retain evidence of having done so to produce for the state upon request; or if the health plan has verifying documentation that the Missouri Medicaid Audit & Compliance (MMAC) unit collected the required disclosures from the providers, then the health plan may utilize the collected disclosures from MMAC:

a. At the stage of provider credentialing and re-credentialing;
b. Upon execution of the provider agreement;
c. Within 35 calendar days of any changes in ownership of the provider; and
d. At any time upon request of the state agency for any of the information described herein.

2.17.6 **Materials and Information for Out-of-Network Providers** – The health plan shall specify the following in writing, 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 telephone 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 120 calendar days from the health plan's notice of resolution of the appeal.
        - The state will reach its decisions within the specified timeframes:
            - ✓ Standard resolution – Within 90 calendar days from the state agency's receipt of a state fair hearing request.
            - ✓ Expedited resolution – Within three business days from the state agency's receipt of a state fair hearing request for a denial of a services 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.
e. Procedure for obtaining member eligibility status;
f. Multilingual and TDD availability and American Sign Language services; and
g. Confidentiality requirements.

2.18 Provider Complaints and Appeals Requirements – The health plan shall establish a provider complaint process and a provider appeal system, which includes access to file a state provider appeal that provides for the timely and effective resolution of any disputes between the health plan and providers. This system shall be specific to providers and shall not replace the member grievance and appeal 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 and appeal system shall apply.

2.18.1 **Definitions** – For purposes of this document, the following definitions shall apply:

a. Provider Complaint – A verbal or written expression by a provider which indicates dissatisfaction or dispute with health plan policy, procedure, claims procedure, or any aspect of health plan functions. All complaints must be logged and tracked by the health plan and/or provider, whether received by telephone, in person, or in writing.

b. Provider Appeal – The mechanism that allows providers the right to appeal actions of the health plan for any of the following reasons:

    1) The denial, in whole or in part, of payment for a service.
    2) A claim for reimbursement not acted upon with reasonable promptness, as defined in Section 376.383, RSMo; or
    3) Is aggrieved by any rule or regulation, policy or procedure, contractual agreement, or decision by the health plan.

c. Provider Appeal Resolution – The written determination concerning a provider appeal.

d. State Provider Appeal Request – A written request asking for a state review of a provider appeal resolution.

e. State Provider Appeal Decision – The written determination concerning a state provider appeal request.

2.18.2 Policies and Procedures:

a. The health plan shall have in place a written Complaint and Appeal system for provider, which defines their rights regarding disputed matters with the health plan. The health plan's complaint and appeals system shall include a complaint process, appeals process, and a state provider appeal process, per Section 208.156, RSMo.

b. The health plan shall have and implement written policies and procedures which detail the operation of the provider complaint process, appeal process, and state provider appeal process. The policies and procedures shall be approved by the health plan governing body and shall be the direct responsibility of the governing body. The health plan shall submit the policies and procedures to the state agency for prior approval.

c. The policies and procedures shall include, at a minimum:

1) A description of how providers file a complaint, provider appeal, or state 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) Identification of specific individuals who have authority to administer the provider complaint and appeal process;

6) That the state agency will maintain an independent state provider appeal process as required by statute. This process shall give providers an opportunity to request a hearing before the Administrative Hearing Commission;

7) A provider may request a state provider appeal, no later than 120 calendar days from the date a provider appeal resolution is upheld through the health plans internal appeal process and not resolved wholly in favor of the provider. If the health plan fails to adhere to the acknowledgement and timing requirements as otherwise specified herein, the provider shall be deemed to have exhausted the health plan's internal level of appeal and may submit a state provider appeal request;

8) A written state provider appeal decision shall be sent to the provider and health plan within 90 calendar days of receipt of all necessary documentation;

9) The health plan shall comply with decisions reached as a result of the state provider appeal process within ten calendar days from receipt of the state provider appeal decision;

10) Upon receipt of a state provider appeal decision, a provider or health plan may file a petition for review with the Administrative Hearing Commission per Section 208.156.8, RSMo; and

11) The health plan shall reprocess a claim or deny or pay consistent with a state provider appeal decision, Administrative Hearing Commission decision, corrective action, or at the single-state agency discretion, even if it is beyond the health plan's timely filing policy.

d. The health plan shall update provider manuals and website information for providers containing the complaint process, appeal process, state provider appeal process, and 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.

e. The health plan shall include a description of the provider complaint and appeal process in the provider manual.

2.18.3 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.

2.19 Quality Assessment and Improvement Requirements:

2.19.1 The state agency's quality assessment and improvement program will consist of internal monitoring by the health plan, oversight by federal and state government, 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 Managed Care Program health plan reports, on-site review topics, and Managed Care Program 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 agency's Quality Improvement Strategy located on the agency's website.

2.19.2 The health plan shall comply with all of the state agency's quality assessment and improvement programs as described herein and when periodically reviewed and updated by the state agency. The state agency will provide the health plan with no less than 90 calendar days' notice if any changes in the format of the quality assessment and improvement programs described herein are requested. The health plan shall comply with all subsequent changes specified by the state agency. 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 specified by CMS. The health plan shall have a quality assessment and improvement program composed of the following:

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 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 that is provided to providers and members.

2.19.3 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 the following:

a. Quality management;
b. Utilization management;
c. Records management;
d. Information management;
e. Care 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.

2.19.4 **Internal Staff** – The health plan shall designate a Quality Assessment and Improvement Coordinator who 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 continuous improvement process must include a focus on health outcomes and action plans for improvement of those outcomes.

b. Be responsible for the health plan's 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. Ensure the health plan's utilization management committee shares utilization data and information with the quality assessment committee.

d. Review critical incidents and all potential quality of care problems as otherwise required herein, of both physical and behavioral health, and oversee development and implementation of continuous assessment and improvement of the quality of care provided to members.

e. Ensure that health education resources are available for the provision of proper medical care to members.

f. Utilize staff in an effective and efficient manner to monitor and assess care delivery.

g. Specify clinical or health services areas to be monitored.

h. 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.

i. 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.

j. Monitor and report the following through the health plan's internal quality assessment and improvement process including:

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 re-credentialing 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) Responsible for monitoring providers to ensure that reports of disease and conditions are made to DHSS in accordance with all applicable state statutes, rules, guidelines, and policies and with all metropolitan ordinances and policies;

8) Responsible for monitoring providers to ensure that control measures for tuberculosis, STDs, and communicable diseases are carried out in accordance with applicable laws and guidelines; and

9) All toll-free telephone nurse hotline activities.

2.19.5 Practice Guidelines:

a. The health plan shall adopt practice guidelines that meet the following guidelines:

1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in particular fields;

2) Consider the needs of 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 provider, and upon request, to members and potential members.

2.19.6 **Critical Incident Reporting** – The health plan shall comply with all health, safety, and welfare monitoring and reporting required by state or federal law. In addition, the health plan shall develop and implement processes and procedures to receive, review, and respond to reports of incidents and quality of care concerns related to services provided, contracted, or funded by the health plan. Reports of incidents and quality of care concerns include those received by the health plan from any source or those referred to the health plan by the state agency.

Addendum 02 added a word to the subparagraph below.

a. At a minimum, the health plan shall document, track, and evaluate ***all of*** the following types of incidents and quality of care concerns:

1) Deaths in which quality of care may have been a contributing factor;
2) Suicides or suicide attempts resulting in serious medical interventions;
3) Homicides or homicide attempts resulting in significant medical interventions;
4) Allegations of physical, sexual, or verbal abuse or neglect;
5) Accidental injury in a facility that results in significant medical intervention;
6) Use of seclusion and/or restraints;
7) AWOL (absence from a facility without permission);
8) Medication errors or adverse medication reactions requiring significant medical intervention; and
9) Quality of care concerns.

b. The health plan shall remediate individual or systemic concerns in a timeframe necessary to ensure the safety and wellbeing of the individual member and other members.

c. The health plan's Quality Assessment Committee shall review trended incident and quality of care data to inform performance improvement opportunities in at least a quarterly basis.

d. The health plan shall submit a report summarizing the total number, outcomes of the health plan's review, and remedial actions taken in response to reported incidents and quality of care concerns.

e. The health plan shall notify the state agency within one business hour of the health plan's awareness of an incident that is high profile. In this context, "high profile" means that the incident is high risk, or is likely to be the subject of news media, or is otherwise controversial in nature.

2.19.7 **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 shall be in the format and frequency specified by the state agency and will be located and periodically updated on the state agency Managed Care Program website under Reporting Schedule and Templates. The state agency will provide the health plan with no less than 90 calendar days' notice of any changes in the format requested. The health plan shall comply with all subsequent changes specified by the state agency. The health plan shall participate in all data validation activities pertaining to such reports, as requested by the state agency.

2.19.8 **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.

2.19.9 **Internal Procedures** – The health plan shall have 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 shall be placed on, at a minimum, clinical areas relating to maternity, pediatric and adolescent development, HCY/EPSDT, family planning, and well woman care, as well as 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 all members in the written monitoring, assessment, evaluation, and improvement plan.

a. Internal policies and procedures shall:

1) Ensure that the utilization management committee has established operating parameters and reports necessary information to the quality assessment committee. 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 utilization management and quality assessment 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 (hereinafter referred to as UM) – 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 health plan's Utilization Management Coordinator shall be responsible for all utilization management activities. The utilization management policies and procedures shall be specific to the State of Missouri's level of care, consistent with the state agency's medical necessity criteria and comply with federal and state parity requirements set forth by MHPAEA, and other standards up to the discretion of the state agency. The health plan's policies and procedures shall provide for an integrated utilization management staff that makes utilization management decisions on both physical and behavioral health issues. The health plan must have appropriately qualified UM review staff who are available by telephone from 8:00 am to 5:00 pm, Monday through Friday, (except for the major holidays) to render UM decisions for providers. UM review staff must be available by telephone 24/7 to respond to authorization requests for inpatient admissions, or the health plan must have policies and procedures that allow for emergency inpatient admissions with authorization the next business day. 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 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. All network providers must be enrolled with the state agency as a Medicaid provider as of January 1, 2018, per 42 CFR 438.602(b) and 438.608(b). 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 timeframe in which the credentialing and re-credentialing must take place. The credentialing process shall include all provisions pursuant to Section 376.1578, RSMo including, at a minimum, ensuring the process does not take longer than 60 business days from receipt of a completed credentialing application. 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 Section 354.442.1 (15), RSMo and 20 CSR 400.7.180, as amended. The health plan shall follow the requirements outlined in the *Managed Care Policy Statements* located and periodically updated on the state agency website at: https://dss.mo.gov/business-processes/managed-care-2023/vendor-documents/.

1) The health plan shall credential and re-credential all in-network providers listed within the contract. Provisionally licensed psychologists and provisionally licensed professional counselors are included in this requirement. Any provider requesting to be credentialed who is currently credentialed by another plan administered by the health plan or its affiliates, its parent company or its parent's subsidiaries or affiliates, and who is enrolled as Missouri Medicaid provider with MMAC requesting to be credentialed and that is currently enrolled shall not be denied. The health plan shall have a simplified and expedited process for providers meeting these criteria.

2) As part of re-credentialing, the health plan shall audit records of PCPs, hospitals, home health agencies, personal care providers, and hospices to determine whether the provider is following the policies and procedures related to advance directives.

3) 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 and control, 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 and periodically updated on the state agency website at Reporting Schedules and Templates.

- The health plan shall collect information from the provider, and retain evidence of having done so to produce to the state agency upon request; or if the health plan has to verify documentation that MMAC has collected the required disclosures from the provider, then the health plan may utilize the collected disclosures from MMAC:

  - ✓ At the state of provider credentialing and re-credentialing;
  - ✓ Upon execution of the provider agreement;
  - ✓ Within thirty-five calendar 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.

4) The health plan shall promptly forward such disclosures or documentation of the disclosures to the state agency, in accordance with specified 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 Health and Human Services, Office of the Inspector General (hereinafter referred to HHS-OIG) within 20 business days from the date it receives 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 controlling interest in the provider, or is an agent or managing employee of the provider) that results in a subcontractor being ineligible for participation. The health plan must retain evidence that it received the proper disclosures or documentation of the disclosures as otherwise specified herein, and produce the same for the state upon request.

5) The health plan shall promptly notify the state agency of any denial of enrollment due to the results of the provider credentialing or re-credentialing process. 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 will, 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 for cause; 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 and periodically updated on the Managed Care Program website at Reporting Schedules and Templates.

6) 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 their license or certification registration; has a 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 (hereinafter referred to as LEIE) and the Excluded Parties List System (hereinafter referred to as 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 (hereinafter referred to as NPPES), located online at https://nppes.cms.hhs.gov/#/, the Missouri Professional Registration Board's website, and any such other state or federal required databases. If the health plan has verifying documentation that MMAC conducted a required screening, then the health plan may utilize the collected screenings from MMAC. The health plan may use the template provided in *Provider and Subcontractor Disclosure* located and periodically updated on the state agency website at Reporting Schedule and 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.

7) The health plan shall accurately and timely load into the health plan's claim adjudication and payment systems, those new subcontracting contracts, subcontracted provider demographic information, changes in subcontracting contract terms, changes in subcontracted provider demographic information, updated prior authorization requirements, and changes to the provider directory.

- The health plan shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a participant and billed to the health plan by the provider:

  - ✓ Newly credentialed provider attached to a new contract within ten business days after completing credentialing;

  - ✓ Newly credentialed hospital or facility attached to a new contract within 15 business days after completing credentialing;

  - ✓ Newly credentialed provider attached to an existing contract within five business days after completing credentialing;

  - ✓ Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within five business days after completing re-credentialing;

  - ✓ Changes in existing contract terms within ten business days of the effective date after the change; and

  - ✓ Changes in provider service location or demographic data or other information related to member's access to services must be updated no later than 30 calendar days after the health plan receives updated provider information.

- Payment shall be made on the next payment cycle following the requirement outlined above. In accordance with Section 376.1578, RSMo, the health plan shall pay for all medically necessary services rendered by a credentialed provider in accordance with the plan's policies to the plan's enrollees subsequent to the date of the provider's initialed and completed packet requesting credentialing.

- In no case shall a provider be loaded into the provider directory who cannot receive payment on the health plan's current payment cycle.

8) Upon request by the state agency, the health plan shall provide a report demonstrating the following:

- Compliance with the credentialing requirements herein including, at a minimum, the average number of days taken to complete credentialing by provider type, and the number of providers who were not credentialed according to the requirements by provider type; and

- Compliance with the required timeframes for loading credentialed providers.

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. The health plan shall report the status and results to the state annually, by March 31, of one clinical and one non-clinical performance improvement project to the state agency.

1) Performance Improvement projects shall include the following:

- An aim statement that clearly specifies the improvement strategy, population, and time period for the project;
- Analysis that the selected are of study is based on a demonstration of enrollee needs, care, and services and is expected to achieve measureable benefits;
- Clear, defined, and measurable goals and objectives that the health plan shall achieve in each year of the project;
- A description of utilization of the Rapid Cycle Process Improvement and the Plan Do Study Act (PDSA) process;
- Measure performance using quality indicators that are objective, measurable, clearly defined, and that allow tracking of performance and improvement over time;
- Implement systematic interventions to achieve improvement in quality;
- Evaluate the effectiveness of the interventions;
- Plan and initiate activities for increasing or sustaining improvement;
- Complete the performance improvement project in a reasonable time period so as to allow information on the success of the performance improvement projects in the aggregate to produce new information on quality of care every year; and
- Standardize performance measures (such as HEDIS or another similarly standardized product).

2) Statewide Performance Improvement Project(s) – The health plan shall participate in a statewide performance improvement project(s) as specified by the state agency. For purposes of this document, a statewide performance improvement project(s) shall be defined as a cooperative quality improvement effort by the health plan, the state agency, and the external quality review organization (hereinafter referred to as 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 health plan has the flexibility to select topics within the parameters below to ensure a successful performance improvement project (hereinafter referred to as a PIP). The health plan shall establish a predetermined timeframe in which the PIP will be conducted, and establish a baseline followed by a minimum of two remeasurement periods. An analysis of results detailing the specific interventions taken and their impact on improvement shall also be conducted. Interventions not resulting in meaningful improvements shall not be continued. The three (3) statewide PIPs shall be:

- Improving Member Satisfaction and Appointment Availability (non-clinical):
  - ✓ The health plan shall set a goal for improving member satisfaction and appointment availability each year by five percentage point.

- Immunizations (clinical – medical):

  - ✓ The health plan shall set a goal to improve the plan-specific HEDIS Childhood Immunizations Status Combo 10 each year by at least two percentage points in alignment with the Quality Improvement Strategy.

  - ✓ The health plan shall evaluate this measure to determine which specific immunizations within this measure are historically low and focus on improvement.

- Impatient re-admissions for Mental Health (clinical-behavioral):

  - ✓ The health plan shall set a goal to improve the plan-specific HEDIS Follow-up After Hospitalization for Mental Illness 30 calendar days each year by at least two percentage points in alignment with the Quality Improvement Strategy.

  - ✓ The health plan shall participate in a multidisciplinary workgroup including the MHD, health plans, behavioral healthcare providers, and stakeholders that collaborate on projects aimed at improving mental health.

  - ✓ The health plan shall not be required to produce an annual evaluation and an EQRO review will not be conducted on this measure, unless specifically requested by the state agency.

2.19.10 Accreditation:

a. The health plan shall obtain health plan accreditation, at a level of "accredited" or better, for the health plan's product from NCQA within 24 months of the first day of the notification from the state agency to proceed with services. The health plan shall maintain such accreditation thereafter and throughout the duration of the contract.

b. If the health plan is new to the state agency's Managed Care Program services, the health plan shall obtain accreditation, at a level of "accredited" or better, for the health plan's product from NCQA within 30 months following notification from the state agency to proceed with services. The health plan shall file its application for accreditation within 90 calendar days of notification from the state agency to proceed with services. 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 cancelation of the contract in accordance with the terms set forth herein. Achievement of provisional accreditation status shall require a corrective action plan within 30 calendar days of receipt of the final NCQA report and may result in cancelation 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 updates to include, at a minimum, the proof of application and all supporting documentation six months after notification from the state agency to proceed with services; and

   2) Status updates to include, at a minimum, the projected date for the on-site reviews 12 months after notification from the state agency to proceed with services.

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.

2.20 Community Health Initiative Requirements:

2.20.1 The health plan shall participate in community health improvement initiatives along with DHSS and LPHAs to include the following:

a. Initiatives that align with the Maternal Child Health Program (hereinafter referred to as MCH), DHSS strategic priorities. DHSS will provide their strategic priorities and a list of corresponding best practices for MCH health improvement initiatives to the health plan. 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:

1) Becoming a member of a regional and/or community-wide MCH planning coalition, or both. Community means a geographic entity (usually a county(ies) with broad based representation from LPHAs, community providers, businesses, local organizations, schools, etc. DHSS will provide information to the health plan about DHSS/MCH strategic priorities. The health plan shall not be required to be the lead agency in establishing a coalition;

2) Being actively involved in the development and implementation of the community strategic plan to implement health improvement programs; and

3) Providing feedback on the community strategic plan and its effectiveness.

b. Upon request by the state agency, initiatives may address identified public health challenges, including increasing immunization rates, asthma education and mitigation, increasing smoking cessation rates, injury prevention, chronic disease prevention and management (in particular diabetes, heart attack, and stroke), breast feeding promotion, oral health promotion, sexually transmitted infection prevention, and lead exposure prevention and management and other member education. This includes providing support to the local agencies, state agency, and DHSS in gathering data to support outcome reporting.

2.21 State and Federal Reviews Requirements:

2.21.1 **General** - In order to ensure that claims presented by a health plan for payment by the state meet the requirements of federal and state laws and regulations and medical necessity criteria, a provider may be required to undergo pre-payment or post-payment claims review (audit) by the state agency. Pursuant to 42 CFR 438.3(h), the health plan shall make available to the state agency, CMS or its outside reviewers, on an annual basis and at any time upon request, access to facilities, 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, at a minimum:

a. On-site visits and inspections of facilities;
b. Health plan staff and member interviews;
c. Review of utilization, denial of services, and other area that will indicate quality of care delivered to members;
d. Medical records review;
e. Financial records review;
f. Review of health plan staff and provider qualifications;
g. Review of all quality assessment procedures, reports, committee activities and recommendation, and corrective actions;
h. Review of complaint, grievance, and appeal processes and resolution;
i. Review of requests for transfers between PCPs within each health plan;
j. Review of fraud, waste, and abuse detection, prevention, and review processes, procedures, cases, and reports;
k. Evaluation and analysis of coordination and continuity of care;

l. Review of the health plan's compliance with the MHPAEA in regards to benefits offered by the health plan as directed by the Medicaid State Plan and the requirements set forth by the CMS final rule regarding MHPAEA in Medicaid. Demonstration of compliance with MHPAEA shall include a review of the following as requested by the state agency:
   1) Compliance with requirements regarding financial limitations;
   2) Compliance with requirements regarding quantitative treatment limitations, such as limits in inpatient days or outpatient visits;
   3) Compliance with requirements regarding non-quantitative treatment limitations including, at a minimum, out-of-network services, prior authorization review process, concurrent review process, retrospective review process, the definition of medical necessity, and step therapy protocols;
   4) Compliance with requirements regarding disclosure requirements;
   5) Whether additional services other that those set forth in the Medicaid State Plan are necessary for compliance with MHPAEA; and
   6) The health plan shall understand and agree that the requirements outlined above are subject to change based upon any updates to the requirements set forth by CMS, once released, at the request of the state agency.

2.21.2 **Service Validation** – The health plan shall make available full detailed claims data including billing provider name, performing or attending provider name, date of service, participant name and DCN, diagnoses, procedure codes, amount billed, and amount paid to the state agency and the state agency's designees for the purpose of validation of services rendered and determination of proper payments.

2.21.3 **External Review** – 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.

2.22 Financial Reporting Requirements:

2.22.1 **Financial Data Reporting** – The health plan shall submit four unaudited quarterly reports and an audited annual report for their Managed Care Program book of business to the state agency's contracted actuary. The health plan shall submit the quarterly 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 may be found at *Health Plan Financial Reporting Form* located on the Managed Care Program website under Reporting Schedules and Templates. Changes to the report format must be approved by the state agency's contracted actuary prior to submission.

a. The unaudited quarterly reports and the audited annual report must be certified by one of the following:

   1) The health plan's CEO;
   2) The health plan's CFO; or
   3) An individual who has delegated authority to sign for, and who reports directly to, the health plan's CEO or CFO.

b. The certified reports must attest, based on best knowledge, information, and beliefs, to the following:

   1) To the accuracy, completeness, and truthfulness of the data; and
   2) To the accuracy, completeness, and truthfulness of the quarterly and annual reports.

      - The health plan shall submit the certification concurrently with the quarterly and annual reports.

2.22.2 **Financial Transparency and Analysis** – Upon request from the state or federal agency (or any person or organization designated by either), the health plan shall submit provider (for all types, e.g. physicians, clinics, hospitals, etc.) specific payment data in the format and for the 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 charges to the Managed Care Programs. This shall include at a minimum, the following:

1) Management service agreements;
2) Delegated CM/DM 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.

c. The health plan shall submit this information quarterly with the quarterly 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 Section 610.21, RSMo.

2.22.3 **Health Plan Encounter Data Questionnaire** – The health plan shall provide the required information in a format and frequency specified by the state agency in the *Health Plan Encounter Data Questionnaire* located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

2.22.4 **Health Plan Hospital Services Reporting** – The health plan shall provide the required information in a format and frequency specified by the state agency in the *Health Plan Hospital Services Report Form*, located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

2.22.5 **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 35 calendar 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 and periodically updated on the state agency website Managed Care Program website under Reporting Schedules and Templates. If the health plan has verifying documentation that the MMAC unit collected the required disclosures from the providers, then the health plan may utilize the collected disclosures from MMAC.

2.22.6 **Physician Incentive Plan Reports** – On an annual basis and in compliance with 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 group is at substantial 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. The 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.

2.22.7 **Third Party Savings Reports** – 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* located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and 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.

2.23 Operational Data Reporting Requirements:

2.23.1 The health plan shall provide the state agency with information concerning uniform utilization, quality assessment and improvement, member satisfaction, complaint, grievance, 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, at a minimum, behavioral health data. The health plan shall cooperate with the state agency in carrying out data validation steps. The following reports are examples of reports that will be required and are subject to revisions.

2.23.2 **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.

2.23.3 **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 and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

2.23.4 **Care Management (CM) Reports** - The health plan shall provide the following reports analyzing and evaluating its CM program using the format and frequency specified by the state agency:

a. *Care Management Member Journey Report* located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates;

b. *Health Care Management Member Survey* located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates; and

c. *Care Management Self Report (Pregnancy Only)* located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

d. *Improvement Plan Report* located and periodically updated on the state agency Managed Care Program website under Reporting and Templates.

2.23.5 **Disease Management (DM) Report –** The health plan shall submit a report to the state agency detailing their member's DM. The *Disease Management Report* is located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates. The DM Report shall be submitted in the frequency specified by the state agency.

2.23.6 **Complaint, Grievance, and Appeals 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 located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

2.23.7 Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Reporting:

a. The health plan shall submit the *Schedule M-1 Claims Payment Summary* for Managed Care Program FQHC/RHC Services in the format and frequency specified by the state agency in the Health Plan Instruction for the Schedule M-I Instructions and Forms located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

b. The health plan shall submit a list of the health plan's in-network FQHCs, RHCs, and CMHCs to the state agency annually and upon request. Please see Attachment 6 – Federally Qualified Health Clinics, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Family Planning, and STD Providers.

2.23.8 **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 and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates. The health plan shall ensure use of the correct technical specifications and template for each reporting period.

2.23.9 **Marketing and Education Materials Verification** – By October 1st of each year, the health plan shall provide the state agency with a written attestation that their marketing plan and all education materials are accurate and compliant with the marketing requirements herein.

2.23.10 Provider Network Reports:

a. The annual access plan must be filed as required by the Missouri Department of Commerce and Insurance (DCI). 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 DCI 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.

c. The health plan shall submit a Network Development and Management report as otherwise specified herein.

2.23.11 Quality Assessment and Improvement Evaluation Reports:

a. Periodic Reports of Quality and Utilization – The health plan shall provide periodic reports regarding CM, quality initiatives, and other quality analysis reports, per the 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:

1) HEDIS Measures – The health plan shall submit the HEDIS measures to 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 and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates..

Addendum 02 revised the subparagraph below.

2) The health plan shall submit to the state agency, the HEDIS certified results for all HEDIS measures that are calculated by the plan. At a minimum, this shall include the following measures: Follow-up After Hospitalization for Mental Disorders (hereinafter referred to FUH); Prenatal and Postpartum Care – ***Timeliness of Prenatal Care*** (PPC); ***Prenatal and Postpartum Care – Postpartum Care (PPC);*** Well Child Visits in the First ***30*** Months of Life ***(0-15 months)***(W***30***); Well Child Visits in the ***First 30 months*** of Life ***(15-30 months)***(W3***0***); Ambulatory Care (hereinafter referred to as AMB); Mental Health Utilization (MPT), and Identification of Alcohol and Other Drug Services (IAD). ***Any HEDIS measures reported using the Administrative method must be reported separately by region. Measures using the Hybrid method must be reported with statewide results.*** Results shall be reported to the state agency on the annual *Healthcare Quality Data Template* located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

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 and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

4) Member Satisfaction Data/Report - The health plan shall submit the Consumer Assessment of Health Plans Study (hereinafter referred to as CAHPS) Questionnaire applicable for the reporting year pursuant to 19 CSR 10-5.010, as amended, and NCQA requirements. 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 two member groups statewide (CHIP and Medicaid/non-CHIP). The template will be provided immediately following the state agency's notification to the health plan to proceed with contract services. Regional CAHPS data may be requested at the state agencies discretion. The health plan shall also submit CAPHS data results to the state agency for healthcare Research and Quality (AHRQ) following AHRQ's standard procedures, and shall provide confirmation to the state when this is completed.

b. Annual Quality Assessment and Improvement (QA & I) Evaluation Report. The health plan shall submit an annual QA & I 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 and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

Addendum 02 deleted a duplicate period.

2.23.12 **Adult and Child Core Sets Reporting** – The health plan shall submit a report on Adult and Child Core Sets that reflect results stratified by several categories: gender, age group (as defined in each measure's specifications), race, ethnicity, and region (urban/rural). The Adult and Child Core Sets Reports shall be submitted in the format and frequency specified by the state agency at the *Adult and Child Core Sets Report* located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

2.23.13 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 and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

2.23.14 **Suspected Fraud, Waste, or Abuse Reports** - The health plan shall provide 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: Case Log* located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

2.23.15 **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 and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

2.23.16 **Mental Health Parity Reports -** The health plan shall provide reports documenting compliance with MHPAEA to the state agency, in the format and frequency specified by the state agency in the *Mental Health Parity Compliance Report Template* located on the state agency Managed Care Program website under Reporting Schedules and Templates.

2.23.17 **Certified Community Behavioral Health Organizations (CCBHOs) -** The health plan shall provide utilization reports to DMH.

2.23.18 **Prior Authorization and Denials Log 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 the *Prior Authorization and Denials Log* specifications located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

2.23.19 **Inpatient Authorization Report** - The health plan shall submit to the state agency, a report of inpatient certifications/prior authorizations and discharges in the format and frequency specified by the state agency as outlined in the *Inpatient Certifications File Specifications*, located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates..

Addendum 02 revised the paragraph below.

2.23.20 **EP*S*DT Self Report – Instructions** - The health plan shall submit to the state agency, a report in the format and frequency specified by the state agency in the *EPSDT Self Report - Instructions* located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

2.23.21 **Institution of Mental Disease (IMD) Services Report** - The health plan shall submit to the state agency, a report of IMD services in the format and frequency specified by the state agency, as outlined in the *Institution of Mental Disease (IMD) Services Report,* located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

2.23.22 **Overpayments Due to Fraud Reports** - The health plan shall submit to the state agency, the following reports in the format and frequency specified by the state agency, as outlined in the *Overpayments Due to Fraud Reporting Template* located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

2.23.23 **Critical Incident Report** - The health plan shall submit to the state agency, the following report in the format and frequency specified by the state agency as outlined in the *Critical Incident Report* located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

a. In addition, the health plan shall develop and implement processes for tracking, reviewing, investigating and correcting quality of care/critical incidents. Correction includes individual and systemic interventions as appropriate. The health plan shall analyze trends and patterns and use the information to provide quality of care to members. Examples of reportable incidents include the following:

1) Suicide and non-suicide death;
2) Death cause unknown;
3) Homicide;
4) Homicide attempt with significant medical intervention;
5) Suicide attempt with significant medical intervention;
6) Allegations(s) of physical, sexual, or verbal abuse or neglect;
7) Accidental injury with significant medical intervention;
8) Use or restraints/seclusion (isolation);
9) Absence from a mental health facility without permission (AWOL);
10) Treatment complication (medication errors and adverse medication reaction) requiring significant medical intervention; or
11) Provider-preventable conditions.

b. The health plan shall submit a report to the state agency 45 calendar days following the end of each quarter summarizing the total number, outcomes of the health plan's review, and remedial actions taken in response to reported incidents and quality of care concerns.

2.24 Third Party Liability Requirements:

2.24.1 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.

2.24.2 **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.

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).

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 as 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.

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) directly above applies even if services were provided by an out-of-network provider. The health plan may require prior authorization for 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 from the out-of-network provider, the member shall 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:

- 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 amount 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 in the subparagraph directly above should be followed.

d. The health plan shall retail up to 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 will 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 will 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 specified 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 will 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.

2.24.3 **Casualty/Tort** - The health plan shall act as an agent of the state agency for purposes of third party reimbursement pursuant to Section 208.215, RSMo as amended. In addition to coordination of benefits,

the health plan shall pursue reimbursement in the following circumstances: Workers' Compensation, Tortfeasors, Motorist Insurance, Liability/Casualty Insurance, Malpractice, and Product Liability.

a. The health plan shall take action to identify those paid claims for members that contain diagnosis codes 800 through 999 (ICD 10-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 will perform a data match with the Missouri 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 will 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. 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.

c. The state agency will 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 will 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 post payment recovery and cost avoidance activities as appropriate based on the information supplied by the data match. 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 state agency will perform a data match with DCI to identify members that DCI has a record of a malpractice claim. The state agency will provide the health plan with the results of the match quarterly, 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. 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

e. The health plan shall perform all research, investigations, and payment of lien-related costs, including at a minimum, attorney fees and costs related to such cases.

f. 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.

g. 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.

h. 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.

2.25 Reinsurance Requirement – The state agency will not administer a reinsurance program funded from capitation payment withholdings.

2.26 **Reserving Requirements –** 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.

2.27 Claims Processing and Management Information Systems:

2.27.1 **General Requirements** - The health plan shall have a Claims Processing and Management Information System (MIS) capable of meeting the 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 PCPs, 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.

2.27.2 **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 Managed Care Program policies and procedures. The state agency will make every effort to give the health plan 60 calendar days' notice of changes in the Managed Care Program that may require the health plan to make system changes in order to comply.

2.27.3 **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 telephone-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.

2.27.4 **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, at a minimum, 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 Sections 376.383 and 376.384, RSMo.

a. The health plan shall perform validation checking for Workgroup for Electronic Interchange (EDI) Strategic National Implementation Process (SNIP) minimum level of four, on claim transactions sent to the health plan. The health plan shall not utilize SNIP compliance Levels 5 through 7 without prior approval from the state agency.

b. 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, at a minimum, 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 shall file a statement with HHS certifying that they comply with the standards and operating rules.

2.27.5 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 is 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 shall void encounter claims if the state agency discovers errors or conflicts with a previously adjudicated encounter claim within 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 shall collect information from providers and report the data to the state agency. As with data completeness, the health plan shall assure the collection and submission of accurate data to the state agency.

    1) The health plan shall maintain at least a 98% acceptance rate on encounter submissions on a monthly basis. The state agency will evaluate the acceptance rate and provide feedback to the health plan on a quarterly basis. If the health plan falls below the 98% monthly acceptance rate, the health plan will be required to work with the state to improve the specific encounter claim error(s) that contributed to the underperformance. Failure to take action to improve these claims within 30 calendar days will result in a corrective action plan from the state agency. If the health plan falls below the 98% monthly acceptance rate and does not comply with the terms of the corrective action plan, liquidated damages will be assessed.

    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. Encounter claims shall not be withheld from submission to the state agency unless prior approval has been granted by the state agency 30 calendar days in advance. If the state agency determines that the health plan withheld claims without obtaining prior approval, the state agency will assess liquidated damages to the health plan.

d. Claims that are submitted, received, but not rejected by the health plan's EDI system are subject to the claims processing rules Sections 376.383 and 376.384, RSMo (Supp. 2014) including interest and penalties available under Missouri law.

    1) The health plan shall reprocess a claim to deny or to pay consistent with a court order, the results of a state fair hearing decision, state provider appeal decision, Administrative Hearing Commission decision, corrective action, or at the single-state agency discretion, even if it is beyond the health plan's timely filing policy.

e. 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 agency, which will be no earlier than the federal compliance date. The state agency will establish requirements specific to Managed Care Program business needs for the transactions used by the health plan to submit the encounter or other data in the message formats detailed below. Any deviations from the HIPAA transaction standards shall be specified in the state agency Companion Guide and communicated to the health plan. The health plan shall submit all encounter data and other data, including encounter data from the health plan, subcontractors, subsidiaries, or delegates in the format specified by the state agency.

1) Claims Transactions:
   - 837P – Professional
   - 837I – Institutional
   - 837D – Dental

2) Remittance Advice:
   - 835

3) Eligibility Inquiry and Response:
   - 270/271

4) Group Premium Payment for Insurance Products:
   - 820

5) 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 in the Health Plan Record Layout Manual:
   - 834

6) ASC X12 Standard Acknowledgement:
   - 824
   - 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).

f. 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.

g. 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.

h. Encounters must be submitted within 30 calendar days of the day the health plan pays the claim and must be received no later than two years from the last date of service.

i. Encounter data must be certified by one of the following:

   1) The health plan's CEO;
   2) The health plan's CFO; 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.

j. The certification must attest, based on best knowledge, information, and belief, as to the accuracy, completeness, and truthfulness of the encounter data.

k. The health plan shall submit the certification to the state agency reporting site (MHD.MCReporting@dss.mo.gov) concurrently with the encounter data.

l. The health plan shall provide encounter data for external quality reviews in the format specified by the state agency.

m. The health plan shall submit the NPI on all encounter claim provider fields corresponding to those fields on a claim form where a provider NPI is required to be reported. The health plan shall submit the NPI with the corresponding unique health plan assigned provider identifier in the provider demographics file.

2.27.6 **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.

2.27.7 Other Electronic Data Exchange:

a. Provider Demographic File - The health plan shall transmit through the provider demographic file, all PCPs assignments, all changes, additions and deletions for all providers, and include a stop date if applicable. 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 – This record layout shall be used to notify the state's contractor of an assignment of a PCP to a participant. Records may be submitted in the same file transmission as Provider Demographic Records.

c. TPL Lead File – This record layout shall be used to supply the health plans with third party liability data for any third party liability updates or data for new enrollees into their health plans. This record layout shall also be used to receive electronic third party liability leads from a health plan and return third party liability error records. This file shall be combined with the daily eligibility file.

d. HBM Baseline Health Data File – This record layout is used to inform health plans of assessment information acquired by the state agency's subcontracted Health Benefit Manager.

2.27.8 **Information Systems Availability** - The health plan shall ensure that critical member and provider Internet and/or telephone-based functions and information including, at a minimum, electronic claims management and self-service customer service functions are available to the applicable system users 24 hours a day, seven 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., Central Standard Time. Unavailability caused by events outside of the health plan's 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 72 hours of the failure or disaster's occurrence.

a. In accordance with Executive Order 07-12 signed by the Governor of the State of Missouri on March 2, 2007, the health plan shall:

1) 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;

2) 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;

3) Support making information available regarding the prices for procedures or services under the program; and

4) 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.

2.27.9 **One Integrated Information System Platform -** The health plan shall have one integrated information system platform for CM and utilization management that provides both physical health and behavioral health information including, at a minimum, claims data, notes, and prior authorizations. The health plan shall have one integrated information system platform implemented by June 30, 2019.

a. If at any time the health plan makes any unilateral decision to make an information system platform change or undergoes a sale or merger and acquisition, the health plan must notify the state agency. The state agency will determine if these events will require significant time and expense from the state agency and provide the health plan with a cost estimate that would be required for the state agency to make the necessary system changes to accommodate the health plan's requested information system change. The health plan shall be responsible for the actual cost as determined by the state agency and such costs will be withheld from future capitation payments.

b. In the event of a contract termination or cancellation associated with a merger or acquisition of the health plan, the health plan shall transfer all necessary data, history records, and other systems in an orderly manner to the successor health plan contractor or the state agency in a format specified by the state agency.

c. By no later than 90 calendar days prior to termination or cancellation of the contract associated with a merger or acquisition of the health plan, the health plan shall assist the state agency and successor health plan contractor in the transition of members, and in ensuring, to the extent possible, continuity of member-provider relationships. In doing this, the health plan shall make available to the state agency and any successor health plan contractor, copies of medical records, member files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient CM of members. In no circumstances shall a Managed Care Program member be billed for this activity.

2.27.10 **Interoperability for Payers** - The health plan shall implement requirements applicable to payers in the CMS "Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIL Managed Care Entities, Issuers of Qualified Health Plans on the Federally-facility Exchanges, and Health Care Providers" final rule (CMS-9115-F) as published in the Federal Register on May 1, 2020 (85 FR 25510). The health plans shall implement: Section III-Patient Access Application Programming Interface (API) (effective January 1, 2021, with enforcement date of July 1, 2021), Section IV[1] Provider Directory API (effective January 1, 2021, with enforcement date of July 1, 2021), and Section V-Payer to Payer Data Exchanges (effective January 1, 2022).

a. The health plans shall implement these interoperability requirements in accordance with the applicable specification of the Office of the National Coordinator's (ONC's) "21st Century Cures Act:

Interoperability, Information Blocking, and the ONC Health IT Certification Program" companion final rule as published in the Federal Register on May 1, 2020 (85 FR 25642), effective June 30, 2020.

2.28 Business Continuity and Disaster Recovery Planning Requirements:

2.28.1 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, at a minimum (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, at a minimum, (natural events, inclement weather, and declared emergencies), systems failures, and systems disruptions.

2.28.2 The BC-DR plan shall, at a minimum:

a. Specify the health plan 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.

2.28.3 The health plan shall periodically, but no less than annually, perform comprehensive tests of its BC-DR plan and update as necessary. Following notification from the state agency to proceed with contract services, the health plan shall make available to the state agency, the health plan's BC-DR plan and any necessary testing results.

2.29 Records Retention Requirements:

2.29.1 The health plan shall maintain books and records relating to Managed Care Program services, operations, and expenditures, including reports to the state agency and source information used in preparation of these reports. For purposes of this section, all books, data, documentation, reports, and source information shall be collectively referred to as "records". The health plan shall comply with all standards for records to be kept as specified by federal law and shall have written policies and procedures for storing all records. Records shall include, at minimum, financial statements, records relating to quality of care, medical records, and prescription files.

2.29.2 The health plan shall maintain and retain the following records for ten years in accordance with 42 CFR 438.3(u).

a. Member grievance and appeal records, member medical records, and any other records pertaining to members;

b. Encounter data, financial reports, any other records used in rate setting, and any other financial reports documenting the solvency of the health plan;

c. Medical loss ratio (hereinafter referred to MLR) reports for each MLR reporting year;

d. Documentation of adequate networks;

e. Ownership and control disclosures related to the health plan and any subcontractor and prohibited affiliation disclosures; and

f. Records resulting from program integrity activities, including referrals or investigations of potential fraud, waste, and abuse, and overpayments identified and recovered.

2.29.3 The health plan shall maintain and retain the following records for seven years:

a. Records for real property and equipment acquired with federal funds – maintain for seven years after final disposition; and

b. Indirect cost rate proposals and cost allocation plans.

2.29.4 If any litigation, claim, negotiation, audit or other action involving the records has been started before the expiration of the applicable retention period, the health plan shall retain the records until completion of the action and resolution of all issues that arise from it or under the end of the regular retention period, whichever is later.

2.29.5 **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, at a minimum, 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 HHS 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 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 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 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 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 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 PCPs, upon request, his or her medical records or copies of medical records must be forwarded to the new PCP within ten business days from receipt of request or prior to the next scheduled appointment with the new PCP, 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.

2.30 Risk Mitigation, Performance Withhold Program, and Remedies for Violation, Breach, or Non-Compliance of Contract Requirements:

2.30.1 **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 continues to risk adjust base capitation rates under a contract(s) awarded in response to this RFP using 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 is provided in Attachment 2, *Actuarial Memorandum*. 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. The state agency will

communicate the results of the quarterly risk adjustment at least 30 calendar days prior to the effective quarter of the risk-adjustment factors with the exception of the initial contract implementation where communication will be provided as soon as possible following open enrollment and auto-assignment.

a. During the initial years following implementation of the AEG, risk adjustment will not be applied to the AEG capitation rates. Instead. A risk corridor will be in place specific to this population to address risk mitigation. It is the state agency's intent to convert to risk-adjusted rates for this population over time and to eliminate the risk corridor program. Timing for the transition from a risk corridor to risk-adjusted rates is at the sole discretion of the state agency.

2.30.2 **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, including value based payment options that enhance the ability to match payment to risk for the health plan and enhance health outcomes. 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.

2.30.3 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 (2.5%) of capitation payments for each contract period. Withhold percentages will not be applied to event 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.

b. The Performance Withhold Program shall consist of NCQA HEDIS measures as specified by the state agency. A baseline year will be established using calendar year HEDIS performance measures and rates. A performance year will be established using the HEDIS performance measures and rates immediately following the baseline year. The baseline and performance years applicable to each SFY contract period are defined in the *Managed Care Performance Withhold Technical Specifications* document located on the state agency Managed Care Program website.

1) Measures and technical resources for all HEDIS measures may be found online at https://www.ncqa.org/hedis/measures/.

c. The health plan shall calculate and provide to the state agency, HEDIS performance measures and rates on an annual basis, no later than August 31st of each year. The state agency will utilize the health plan provided data along with the NCQA Quality Compass percentiles to determine their performance improvement and the amount of the two and a half percent (2.5%) capitation payments to be released to each health plan according to the requirements herein.

d. The total performance withhold paid to a health plan shall not exceed two and a half percent (2.5%) of the capitation payments made during the performance year.

1) Any of the selected HEDIS measures that are not reported by a health plan will receive zero percent (0.00%) performance withhold payout.

e. The state agency will monitor the performance withhold program closely and has the authority to change the program as necessary. This includes evaluating the model and payout methods.

1) Baseline and Performance Year - Baseline and performance years shall be established according to the *Managed Care Performance Withhold Technical Specifications* located and periodically updated on the state agency Managed Care Program website.

2) Evaluation of Performance - The health plan shall submit annual HEDIS measures and rates to the state as required in this section and outlined in the *Managed Care Performance Withhold Technical Specifications* located and periodically updated on the state agency Managed Care Program website. Upon release of the NCQA Quality Compass, the state will evaluate and compare the health plan's HEDIS measures and rates to the health plan's baseline year rates and rates across the nation. The review will be conducted according to the evaluation of performance within the *Managed Care Performance Withhold Technical Specifications,* also located and periodically updated on the state agency Managed Care Program website.

- Percentile requirements refer to the NCQA Quality Compass percentile rankings for MCOs for the measurement (performance) year being evaluated.

- Percentage point increases or decreases shall be measured; not a total percentage of improvement or decline.

  - Example: A two-percentage point increase over 10% is 12%.

- Standard rounding (1.487 = 1.49) will be utilized to arrive at the final value out two decimal places for both the baseline and performance year as well as comparisons to benchmarks.

3) Performance Withhold Payout Models - The Performance Withhold Program will have two payout models, the Standard Model and the Supplemental Model. The state will combine the Standard and Supplemental payouts to arrive at the total performance withhold to be released to the health plan. An attachment detailing the method applied will be provided to the health plan with their annual Notice of Performance letter. The total performance withhold paid to a health plan shall not exceed two and a half percent (2.5%) of the capitation payments made during the performance year.

f. 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.

g. The Performance Withhold Program arrangement shall not be renewed automatically; it must be made available to both public and private contractors under the same terms of performance; and, does not condition the health plan's participation in the withhold arrangement on the health plans entering into or adhering to intergovernmental transfer agreements.

2.30.4 Minimum Medical Loss Ratio Requirements:

a. Consistent with 42 CFR 438.8 (c), the health plan shall meet a minimum 85%) medical loss ratio (MLR) for the MLR reporting year, which aligns with the rating period under the contract(s) to be awarded as a result of this RFP. The state agency reserves the right to reduce or increase the minimum MLR term of the contract and to modify the aggregation method for the calculation and reporting of the MLR, provided that any such change (i) shall only apply prospectively, (ii) exclude any retroactive increase to allowable direct medical services, and (iii) shall comply with federal and state law.

b. For purposes of this requirement, the following calculation standards will be used to determine compliance with the minimum MLR as further defined in the MLR Template Instructions for the applicable MLR reporting year. The health plan shall submit reports in the format and frequency required by the state agency in the *MLR Template* and the *MLR Template Instructions* located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates. The health plan shall ensure use of the correct technical specifications and template for each MLR reporting year. The resulting percentage of the numerator divided by the denominator, plus any applicable credibility adjustment factor, must be at least 85% for the MLR Reporting Year.

1) Numerator - Sum of the health plan's incurred claims, activities that improve health care quality, and fraud prevention activities. Note that expenditures for fraud prevention activities will not be included in the MLR numerator until CMS adopts a standard for the private market at 45 CFR Part 158.

2) Denominator - The adjusted premium revenue, which is the result of subtracting the health plan's federal, state, and local taxes and licensing and regulatory fees from premium revenue.

Addendum 02 revised and added language to the subparagraph below.

3) Aggregation Method - The health plan shall calculate the MLR for the MLR Reporting Year on a statewide basis for the AEG, non-AEG, ***and Specialty Plan*** populations separately.
4) Credibility Adjustment - A credibility adjustment factor will be applied to the health plan's MLR if experience is deemed to be partially credible. The credibility adjustment factors and standards for credibility will be published by CMS for the MLR reporting year. In the event CMS has not issued Medicaid credibility adjustment factors for the applicable MLR reporting year, the health plans will apply the credibility adjustment factors issued by CMS for the private market.

c. The health plan shall submit a detailed explanation of administrative agreements or operational arrangements or practices with the health plan's parent organizations on an annual basis, in a template specified by the state agency that may include, at a minimum, allocation methodology, full-time equivalents, salary, benefits and general administrative overhead.

d. The health plan shall issue its final calculation in writing ten months after the close of the MLR reporting year or termination of the contract. The elements of the required report are specified in the *Medical Loss Ratio Template Instructions*. If the state agency disputes the health plan's calculation, it will advise the health plan and the health plan will have 21 calendar days to provide written notice of dispute of the state agency's determination. Thereafter, the parties shall informally meet to resolve the matter; such meeting must take place within 14 calendar days of the state agency's receipt of the health plan's dispute. If the parties cannot informally resolve the matter, the health plan may exercise its remedy rights under other sections of the contract.

Addendum 02 revised and added language to the subparagraph below.

e. The MLR remittance shall be determined separately for AEG, non-AEG, ***and Specialty Plan*** populations. If the health plan's MLR is less than 85% for the MLR Reporting Year for either population, the health plan shall owe a remittance to the state agency in the amount that would bring the MLR experience to 85% for that population. The remittance is due within 30 calendar days of notification from the state agency that a remittance is due, and the requirement to pay the remittance survives termination of the contract.

2.30.5 Adult Expansion Group (AEG) Risk Corridor:

a. A risk corridor on the Medicaid covered service expenditures specific to the AEG will be applied for the contract period(s) as specified by the state agency to protect the health plan, the state agency, and the federal government against differences in the assumptions used to develop the service component of the capitation rates and actual health plan experience. The health plan shall understand and agree that the health plan and the state agency will share in excess gains or losses generated under this arrangement. The state agency reserves the right to extend the risk corridor over the term of the contract or to modify the methodology, including risk bands prior to the start of any future rating periods, consistent with federal requirements under 42 CFR § 438.6(b).

b. For purposes of this requirement, the risk corridor shall be limited to the covered services component of the capitation rates and the following calculations standards shall apply:

1) Expected Medicaid Service Expenditures – The state agency provided service component of the per member, per month capitation rates and event payment for deliveries for the AEG, including any rate adjustments made during the contract period as specified herein and the number of member months and delivery events specific to the health plan for each capitation rate and the delivery payment. The service component of the capitation rate (and delivery event payment) multiplied by the member months (and deliveries) will determine the aggregate amount of Expected Medicaid Service Expenditures during the rating period for the AEG.

2) Actual Medicaid Service Expenditures – The sum of all service expenditures for covered services and state agency approved ILOS for all AEG members incurred during the contract period as specified herein. Services provided at the discretion of the health plan, excluding in lieu of, and administrative expenditures shall not be included in the calculation of Actual Medicaid Service Expenditures during the rating period for the AEG.

c. The health plan shall submit its final calculation of the aggregate Expected Medicaid Service Expenditures and Actual Medicaid Service Expenditures by no later than ten months after the close of the state fiscal year, allowing for at least eight months of claims runout and updated estimates of incurred but not reported expenditures. The state agency will review submissions against submitted encounter data and health plan financial reporting forms from the health plan and if the state agency disputes the health plan's calculation, the state agency will advise the health plan and the health plan will have 21 calendar days to provide written notice of dispute of the state agency's determination. Thereafter, the state agency and the health plan shall meet informally to resolve the matter within 14 calendar days of the state agency's receipt of the health plan's dispute. If the matter cannot be resolved, the health plan may exercise its remedy rights as described elsewhere herein.

d. The health plan shall understand and agree that the health plan and the state agency will share in the excess gains or losses during the rating period for the AEG based on the percentage difference from the Expected Medicaid Service Expenditures as follows:

Percent Difference from Expected Service Expenditures	Health plan share in excess or losses	State agency share in excess or losses
Amounts greater than 5 percent under Expected Expenditures	0%	100%
Amounts greater than 2 percent but less than or equal to 5 percent under Expected Expenditures	50%	50%
Amounts within +/- 2 percent of Expected Expenditures	100%	0%
Amounts greater than 2 percent but less than or equal to 5 percent over Expected Expenditures	50%	50%
Amounts greater than 5 percent over Expected Expenditures	0%	100%

e. Any amounts owed to the state agency from the health plan based on the risk corridor shall be paid within 30 calendar days of notification from the state agency that amounts are due. Any amounts owed to the health plan by the state agency will be paid with the next applicable monthly capitation payment. Any payments from the health plan or receipts from the state agency will be considered in the MLR calculation consistent with 42 CFR § 438.8(f)(2)(vi) and specified herein under "Minimum Medical Loss Ratio Requirements" of this contract.

2.30.6 **Liquidated Damages** - The health plan shall understand and agree 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 herein, the health plan shall understand and agree that the amounts identified below as liquidated damages shall be reasonable and fair under the circumstances.

a. Reports and Deliverables - For each business 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 health plan 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.

Addendum 02 revised, deleted, and added items in the table below.

MONTHLY REPORTS	
Report Requirement	**Liquidated Damage Assessment**
Member Grievance and Appeal Report	$100.00 per day per report or deliverable.
Monthly provider exclusion letter	$100.00 per day per report or deliverable.
Health Plan Hospital Services Reporting Form	$100.00 per day per report or deliverable.
DELETED	***DELETED***

QUARTERLY REPORTS	
Report Requirement	**Liquidated Damage Assessment**
Third Party Savings Reports	$100.00 per day per report or deliverable.
Provider Complaint, Grievance, and Appeal Report	$100.00 per day per report or deliverable.
Timeliness of Claims Adjudication Report	$100.00 per day per report or deliverable.
Care Management Self Report (Pregnancy Only)	$100.00 per day per report or deliverable.
Disease Management Report	$100.00 per day per report or deliverable.
Care Management Member Journey Report	***$100.00 per day per report or deliverable.***
Improvement Plan Report	***$100.00 per day per report or deliverable.***
Call Center Report	$100.00 per day per report or deliverable.
Prior Authorization and Denials Log Report	$100.00 per day per report or deliverable.
Overpayments Due to Fraud Quarterly Report	$100.00 per day per report or deliverable.
Unaudited Health Plan Financial Reporting Form Must be provided to the state agency's contracted actuary.	$100.00 per day per report or deliverable.

SEMI-ANNUAL REPORTS	
Report Requirement	**Liquidated Damage Assessment**
Health Plan Encounter Data Questionnaire	$100.00 per day per report or deliverable.

ANNUAL REPORTS	
Report Requirement	**Liquidated Damage Assessment**
Health Care Management Member Survey	$100.00 per day per report or deliverable.
Provider Preventable Conditions Report	$100.00 per day per report or deliverable.
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 Provider Incentive(s) Status	$100.00 per day per report or deliverable.
Disclosure of Member Incentive(s) Status	$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 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.

ANNUAL REPORTS	
Report Requirement	**Liquidated Damage Assessment**
Suspected Fraud, Waste, and Abuse Report	$100.00 per day per report or deliverable.
Mental Health Parity Compliance 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.
Overpayments Due to Fraud Annual Report	$100.00 per day per report or deliverable.
Trends in Missouri Quality Indicators to the Department of Health and Senior Services	$100.00 per day per report or deliverable.
HEDIS Indicators by Managed Care Health Plans Within Regions, Live Births	$100.00 per day per report or deliverable.
Medical Loss Ratio Report for the MLR Reporting Year	$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.	
Deliverable Requirement	**Liquidated Damage Assessment**
Schedule M-1 Claims Payment Summary for Managed Care FQHC/RHC Services	$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 provider 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.
Offerings of new programs.	$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 and all marketing and member education materials.	$100.00 per day per report or deliverable.
Annual marketing attestation.	$100.00 per day per report or deliverable.
Gifts offered during any community activity.	$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.

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.	
Deliverable Requirement	**Liquidated Damage Assessment**
Member grievance and appeal system notices.	$100.00 per day per report or deliverable.
Member grievance and appeal system policies and procedures.	$100.00 per day per report or deliverable.
Member flyer explaining grievance and appeal 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, member 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.
As required herein, provide access to members' medical records within 30 calendar days of request. Provide access to a single or small volume of medical records within five 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.
As required herein, provide Children's Division or FCCM case manager access to members' medical records within ten business days of receipt of written 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 calendar days of a written request.	$500.00 per calendar day per report or deliverable.
Furnish provider/subcontractor disclosure information annually at contract renewal or within 35 calendar 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.

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.	
Deliverable Requirement	**Liquidated Damage Assessment**
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 Managed Care Program 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, third, or fourth 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 cancelled.	$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.	$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 in the chart below:

Addendum 02 deleted an item in the table 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 does not comply 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.
DELETED	***DELETED***
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 comply with the marketing and member education requirements as outlined herein.	$100.00 for each deliverable that is not compliant.
Failure to comply with the written requirements as outlined herein.	$100.00 for each deliverable that is not compliant.
Failure to submit marketing and member materials as required herein.	$500.00 per day for each calendar day in which the health plan has distributed member materials that have not been submitted to the state agency.
Failure to comply with timeframes for providing materials as required herein.	$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 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 load credentialed providers within the time frames required herein.	$100 per provider per day for each day that loading requirements were not met.
Listing a provider in the provider directory which cannot receive payment on the health plan's current payment cycle.	$500.00 per provider per day for each day the provider is listed in the directory and cannot receive payment.
Failure to maintain an accurate provider directory on the health plan website.	$500.00 per provider per day for each day the online provider directory includes inaccurate information.
Failure to meet the requirement for 72% of PCPs accepting new members based on secret shopper survey results.	$1,000.00 per occurrence
Failure to meet the requirement for 58% of psychiatrists accepting new members based on secret shopper survey results.	$1,000.00 per occurrence
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 in the tables above, the state agency reserves the right to assess a general liquidated damage of $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 understand and agree 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 understand and agree that such liquidated damages shall either be deducted from the health plan's capitated payments pursuant to the contract or be paid by the health plan as a direct payment to the state agency, at the sole discretion of the state agency.

2.30.7 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.

2.30.8 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 will notify the health plan in writing that the health plan shall be charged (at the state agency's discretion) either the actual 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 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 will 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 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" shall be 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 business days of receipt of the notice of deficiency, fails to submit a revised correction action 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, at the state's discretion, save that for any month the total amount withheld shall not exceed 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 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, at 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.

2.30.9 **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 will notify the health plan in writing of the determination of the non-compliance, the action(s) that will be taken, and 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 will require the health plan to recall the previously authorized marketing materials.

b. The state agency will suspend enrollment of new members to the health plan.

c. The state agency will 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 will continue to deduct such payment until correction of the failure.

d. The state agency will 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 will prohibit future marketing activities by the health plan for an amount of time specified by the state agency.

2.30.10 **Basis for Imposing Intermediate Sanctions** - In addition to the language above, the state agency may impose intermediate sanctions when the health plan acts or fails to act as specified as detailed 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. The 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 Managed Care 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.

2.30.11 **Types of Intermediate Sanctions** - The types of intermediate sanctions that the state agency may impose upon the health plan include the following:

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 State Provider Incentive Program or the Federal Physician Incentive Plan 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 Managed Care Program. The state agency will 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.

2.30.12 **Special Rules for Temporary Management** - The state agency will 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, at a minimum, 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 will 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 will 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.

2.30.13 **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 will have the right to implement any other legal processes deemed necessary including, at a minimum, 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.

2.30.14 **Federal Sanctions** - Section 1903(m)(5) of the Act vests the Secretary of HHS 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 HHS under the authority of Section 1903(m)(5) of the Act or 42 CFR 438.730. Payments may be denied for reasons including, at a minimum, 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 HHS, the state agency, an individual, or to any other managed care entity; or

d. Failure to comply with the requirements for the Federal Physician Incentive Plan as specified herein and as set forth (for Medicare) in Section 1876(i)(8) of the Act.

2.30.15 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 will provide the health plan a pre-termination hearing. The state agency will:

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.

2.30.16 If the state agency receives written notice from HHS 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 operate as an HMO, the Division of Purchasing may cancel the contract with the health plan pursuant to contract cancellation provisions contained herein.

2.31 **Access to Premises Requirements -** During normal business hours (defined as 8:00 a.m. through 5:00 p.m., Central Standard Time, 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.

2.32 Advance Directives Requirements:

2.32.1 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 Missouri law to make decisions concerning medical care.

2.32.2 The health plan shall provide education to the health plan's personnel and members on issues concerning advance directives.

2.32.3 The above provisions shall not be construed to prohibit the application of any Missouri law that allows for an objection on the basis of conscience for any provider or agent of such provider.

2.33 Fraud, Waste, and Abuse Requirements:

2.33.1 Definitions:

a. Medicaid Managed Care fraud shall be defined as a known false representation, including the concealment of a material fact that was known or should have been known through the usual conduct of his/her profession or occupation, or any type of intentional deception or misrepresentation made by an entity or person in a capitated MCO, Primary Care Care Management (hereinafter referred to 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.

b. Medicaid Managed Care abuse shall be defined as 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 may be committed by an MCO, health plan, subcontractor, provider, state employee, Medicaid beneficiary, or Medicaid managed care member, 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, health plan, 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.

2.33.2 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 during the readiness review 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, at a minimum, the following components:

1) A provision stating that if a network provider submits improper or fraudulent billings to the Managed Care Program health plan, any recoveries associated with the improper or 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 the improper or fraudulent billing is identified and recovered by the health plan in a period where cost reports have not been submitted by the Managed Care Program 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 improper or fraudulent billings in the cost report. However, if the state agency identifies the improper or fraudulent billings during the course of an investigation or audit of the provider's billing, the state will recover the amounts regardless of the time period in which the billings were submitted;

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 shall be supervised by and reports to the CEO, Health Plan Administrator, or the governing body. The health plan shall also comply with the fraud, waste, and abuse staffing requirements otherwise specified herein;

3) A procedure to ensure effective lines of communication between the compliance officer and the health plan's personnel;

4) A 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) A description to include documentation specified by the state agency, of the health plan's required anti-fraud and training/certification program and the training modules and certifications issued, that shall be submitted to the state agency by no later than October 1st, on an annual basis;

12) Inclusion of information about fraud, waste, and abuse identification and reporting in provider and member materials; and

13) Enforcement of standards through well-publicized disciplinary guidelines.

c. The health plan's activities to combat fraud, waste, and abuse shall include, at a minimum, 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 Managed Care Program members are served under the contract;

3) Verifying eligibility prior to the member 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 in responding to requests from the state agency;

8) Developing procedures to monitor utilization/service patterns of providers, subcontractors, and beneficiaries; and

9) Participating in trainings or meetings related to program integrity efforts as directed by the state agency or MFCU.

d. The health plan shall notify the state agency of all suspected fraud or abuse, as described 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. The health plan shall initiate an investigation within seven business days, to gather facts regarding any suspected fraud, waste, or abuse by providers or members. Investigations shall be initiated when notification of suspected fraud, waste, or abuse comes from, at a minimum, hotline calls, e-mail notifications, or telephone communications from the state agency, the MFCU, other outside entities or agencies, providers, members, or via any aberrant or suspicious billing identified by the health plan personnel or analytic software. If the health plan's preliminary investigation supports a finding of suspected fraud or abuse on the part of a provider or member, the health plan must submit a referral form to the state agency and the MFCU as soon as possible and no later than within two business days of notification of the finding. The referral may be submitted using the Missouri Referral Form or the health plan's own form; however, the information documenting the investigation for referral to the state agency and the MFCU shall include the following information: the allegation and date and source of the original complaint or tip; the provider's name, Medicaid provider number of provider's NPI; the relevant statutes and regulations violated or considered; the

results of the investigation, the covered conduct, the period of time at issue; the estimated identified overpayment; a summary of the interviews conducted; the encounter data submitted by the provider during the time period at issue; and all supporting documentation obtained associated with the investigation. After submitting the fraud referral, the health plan will take no further action on the specific allegation until the state agency responds. If the state agency notifies the health plan that the fraud referral is declined, the health plan must proceed with its own investigation. If the state agency notifies the health plan that the fraud referral is accepted, the health plan will be instructed as to what further actions, if any, they may take which will not impair investigation by the MFCU or other law enforcement agency. The health plan must provide the MFCU access to conduct private interviews of the health plan's personnel, subcontractors and their personnel, and any witnesses to the suspected fraud.

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. This required level of cooperation includes, at a minimum, in person availability of health plan personnel and subcontractor personnel (as applicable) for interviews, consultation, grand jury proceedings, pre-trial conferences, and hearings, at their own expense.

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. The health plan and its subcontractors shall seek to reduce prospective financial loss to fraud, waste, and abuse when fraudulent and criminal activity is suspected through pre-payment or post-payment review, audit or investigation. The health plan may mitigate loss of funds to fraud by employing procedures including, at a minimum, pre-payment edits, prior authorization, medical necessity review, verification of services being rendered as billed, payment withhold in part, direct education and technical assistance to the provider, corrective action plans, termination of the provider agreement (with cause), or other remedies appropriate to the situation and of progressive severity if the provider's non-compliance continues or escalates.

h. The health plan shall have a provider sanction and termination policy consistent with the requirements of 13 CSR 70-3.030 (*see* https://www.sos.mo.gov/cmsimages/adrules/csr/current/13csr/13c70-3.pdf), 42 CFR 455.416, 42 CFR 438.610, and any other federal or state laws governing provider participation in federal health care programs. In determining whether termination of the provider agreement is the appropriate sanction, the health plan should consult 13 CSR 70-3.030(5)(A) for sanctionable violations and assess the severity of the provider's conduct or demonstrated pattern of conduct. If termination of the provider is the appropriate sanction, the health plan's termination notice shall address, at a minimum, the general allegations as to the nature of the termination, the effective date of the termination, and any appeal rights available to the provider. The effective date of termination shall comply with 13 CFR 70-3.030(5)(C).

i. 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.

2.33.3 Member Lock-In:

a. The health plan shall conduct a member lock-in program in accordance with 13 CSR 65-3.010, 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 shall not be responsible for the implementation of a lock-in program for pharmacy services; this is the responsibility of the state agency.

2.33.4 **Fraud, Waste, and Abuse 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 specified by the state agency in the *Fraud, Waste or Abuse Activities Report* located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates. The health plan shall follow the requirements outlined in the *MO HealthNet Managed Care Policy Statements,* also located and periodically updated on the state agency Managed Care Program website.

2.33.5 Other Fraud, Waste, and Abuse Reporting:

a. The health plan shall report to the state agency, within one 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 Managed Care Program 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 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 will 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).

d. The health plan shall review all referrals sent to it by the state agency or by the MFCU. The health plan shall report back to the state agency within a timely manner, not to exceed 90 calendar days, regarding the status. The health plan shall report what review was done, what the findings were, and what action(s), if any, were taken. If after 90 calendar days the health plan's investigation is not complete, the health plan shall provide that information as a status report and shall continue to advise the state agency every 90 calendar days of its progress until the investigation is complete or closed.

2.33.6 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 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 specified by a provider that has been excluded from participation in federal health care programs by the OIG of the HHS under either 1128 or section 1128A of the Act, except as permitted under 42 CFR 1001.1801 and 1001.1901.

c. The health plan may access debarred and OIG (https://oig.hhs.gov) sanction information on the Internet. The health plan shall also access information from the Division of 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 and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates, when the health plan learns that a provider in its network has been debarred. The state agency will report such information to the Secretary of HHS, as required by 42 CFR 438.610(d).

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 will conduct a periodic review to determine if appropriate exclusions and corrective action have occurred.

2.33.7 **Disclosure of Ownership and Control Information, Criminal Convictions, and Significant Business Transactions** - Within 35 calendar 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 and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates. If the health plan has verifying documentation that the MMAC unit collected the required disclosures from the providers, then the health plan may utilize the collected disclosures from MMAC.

2.33.8 In accordance with 42 CFR 455.106(b), the state agency shall notify the HHS OIG within 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).

2.33.9 The state will 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.

2.33.10 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); have failed to renew license or certification registration; have revoked professional license or certification; or have 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/. If the health plan has verifying documentation that the MMAC conducted a required screening, then the health plan may utilize the collected screenings from MMAC.

2.34 Other Administrative Requirements:

2.34.1 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 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.

2.34.2 **Consumer Advocacy Project Meetings** - The health plan shall meet with the state agency's Consumer Advocacy Project three 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 shall be face-to-face with the state agency's Consumer Advocacy Project.

2.35 Other State and Federal Legal Compliance Requirements:

2.35.1 Unless otherwise specified herein, the health plan shall furnish all materials, labor, facilities, equipment, and supplies necessary to perform the service required herein.

2.35.2 Within five business days after the state agency's notification to the health plan to proceed with contract services, the health plan shall submit a written identification and notification to the state agency of the name, title, address, and telephone number of one 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.

2.35.3 The health plan shall be responsible for implementation of the Managed Care Program as required herein.

2.35.4 The health plan shall understand and agree that the Managed Care Program is subject to modification by the Missouri General Assembly, the State of Missouri, and the HHS. 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.

2.35.5 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.

2.35.6 The health plan shall understand and agree that the State of Missouri (its departments and employees) does not maintain commercial liability insurance.

2.35.7 Members are the intended beneficiaries of the contracts and as such are entitled to the remedies accorded to third party beneficiaries under the law.

2.35.8 The health plan shall be prohibited from using Managed Care Program 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.

2.35.9 DCI regulates the health plans licensed in Missouri including their financial stability. Therefore, the health plan shall comply with all DCI applicable standards.

2.36 Actions Upon Expiration, Termination, or Cancelation of Contract Requirements:

2.36.1 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 90 calendar days of contract expiration, termination, or cancellation.

2.36.2 Upon expiration, termination, or cancelation of the contract, the health plan shall promptly supply all information necessary for the reimbursement of any outstanding claims.

2.36.3 In the event the contract is cancelled, the state agency will 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 will notify all members of the date of termination and the 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.

2.36.4 In addition, for 365 calendar days after the 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, at a minimum, 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.

2.36.5 In the event of a contract termination or cancelation associated with the merger or acquisition of the health plan, the health plan shall transfer all necessary data, historical records, and other systems in an orderly manner to a successor health plan contractor or the state agency in a format specified by the state agency.

2.36.6 90 calendar days prior to the termination or cancelation of the contract (whether pursuant to the terms of the contract, the sale of the health plan or otherwise), the health plan shall assist the state agency and successor health plan contractor in the transition of members, and in ensuring, to the extent possible, continuity of member-provider relationships. In doing this, the health plan shall make available to the state agency and any successor health plan, contractor copies of medical records, member files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient care management of members. In no circumstances shall a Managed Care Program member be billed for this activity.

2.36.7 Upon expiration, termination, or cancelation of the contract (whether pursuant to the terms of a contract(s) awarded in response to this RFP, the sale of the health plan or otherwise), the state agency shall withhold 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 functions specified above, including the orderly transition of necessary data, history records, and other systems, the withheld portion of the capitation will be paid to the health plan. The health plan's failure to comply with such functions shall result in the health plan's forfeiture of the 30% withhold, or a portion thereof.

2.37 Sexual Harassment Policy Requirements - 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.

2.38 **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:

2.38.1 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.

2.38.2 In addition to the base capitation payment specified above, after receipt of qualifying encounter data from the health plan, the state agency shall make a one-time event payment for the following:

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. On qualifying delivery encounter data the ICD-10 Diagnosis Code must be one of the first five diagnoses on the encounter claim. Please see the *Delivery Kick Payment Policy* listing the qualifying delivery encounter data ICD-10 Diagnosis codes located on the state agency Managed Care Program website. 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 delivery. Monthly capitation payments will continue to be paid for pregnant women during their pregnancy.

b. Following a birth of a very low birth weight newborn (less than 1500 grams), 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 very low birth weight newborn during the first year of life not already reimbursed through the per member, per month capitation payment. On qualifying NICU, encounter data, the very low birth weight newborn ICD-10 Diagnosis Code must be one of the first five diagnoses on the encounter claim. Please see the *NICU Payment Policy* listing the qualifying NICU encounter data ICD-10 Diagnosis codes located on the state agency Managed Care Program website.

2.38.3 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.

2.38.4 The health plan shall understand and agree 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.

2.38.5 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.

2.38.6 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 received from the state agency, the state agency must be notified and reimbursed within 30 calendar 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.

2.38.7 The health plan must have a process for providers, whether in-network or out-of-network, to report in writing overpayments received, specifying the reason for the overpayment, and to return the overpayment to the health plan within 60 calendar days after the date on which the overpayment was identified. A provider has identified an overpayment when the provider has actual knowledge of the existence of an overpayment or acts in reckless disregard or with deliberate indifference that an overpayment exists. The provider may request that the health plan permit installment payments of the refund; such request shall be agreed to between the health plan and the provider. The health plan shall inform all providers that overpayments identified by a provider and not self-reported within the 60 calendar day timeframe may be considered false claims and may be subject to referrals as credible allegations of fraud and subject to payment suspension in accordance with 42 CFR 455.23.

a. The health plan must report all overpayments identified, either through provider self-reporting as otherwise described herein or through the health plan's own investigation, or recovered from providers, specifying those overpayments due to suspected fraud on a quarterly basis to the state agency in a format specified by the state agency herein.

b. The health plan may recoup and retain overpayments made to providers that were self-reported by the provider or identified through the health plan's investigation within timeframes determined by the state agency, unless the following circumstances apply:

3) The issues, services, or claims that are the basis of the recovery are currently being investigated by the state agency, or its designees, or are the subject of pending federal or state litigation or investigation;

4) The state agency, or its designee, independently notified the provider that an overpayment existed;

5) The health plan failed to comply with the timeframes specified by the state agency that would otherwise entitle the health plan to retain the recovered overpayment; or

6) The recovery results from a False Claims Act case.

c. The health plan must report annually to the state agency, and any specified designee, on all overpayment recoveries, regardless of whether the health plan was entitled to retain the recovery, in a timeframe and format specified by the state agency herein.

2.38.8 Unauthorized Programs or Activities:

a. Should any part of the scope of work under a contract(s) awarded in response to this RFP relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the health plan must do no work on that part after the effective date of the loss of program authority. The state will adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If a health plan works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the health plan will not be paid for that work. If the state paid the health plan in advance to work on a no-longer-authorized program or activity and under the terms of a contract(s) awarded in response to this RFP, the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the health plan worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the health plan, the health plan may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

2.39 Business Associate Provision Requirements:

2.39.1 All references to the term "contractor" throughout this section shall be deemed to mean "health plan".

2.39.2 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.

2.39.3 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.

2.39.4 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 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 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 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 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 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 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 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.

2.39.5 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.

2.39.6 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.

2.39.7 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. MANAGED CARE SPECIALITY PLAN SCOPE OF WORK

The requirements in this section apply only to the health plan selected as the Specialty Plan and to the service delivery for members enrolled in the Specialty Plan. All requirements in Section 2 that apply to the General Plan also apply to the Specialty Plan, unless otherwise indicated herein. In the event there is a conflict of requirements between requirements in this Section and other Sections, the requirements in this Section shall control.

3.1 General Requirements:

3.1.1 The contractor (hereinafter referred to as the Specialty Plan) shall provide Specialty Plan services for the state agency, in accordance with the provisions and requirements stated herein and to the sole satisfaction of the state agency.

3.2 Specialty Plan Medicaid Reform and Transformation Requirements:

3.2.1 Value-Based Purchasing Strategies - The expectations set forth herein under "Value-Based Purchasing Strategies" shall not apply to the Specialty Plan for at least the first 12 months of the contract. Upon the request of the state agency, the Specialty Plan shall support the design and implementation of value-based purchasing or other payment reform initiatives for the Specialty Plan identified by the state agency.

3.3 **Specialty Plan Administration Requirements -** In addition to the personnel and organizational requirements specified herein under "Health Plan Administration," the Specialty Plan shall comply with the following personnel and organizational requirements. The health plan may share personnel with the Specialty Plan as long as the health plan and Specialty Plan demonstrate that the responsibilities are being met, unless otherwise specified below. The positions listed below are full time, unless otherwise specified below.

3.3.1 **Specialty Plan Program Director** who shall report to the Health Plan Administrator and shall be fully dedicated and responsible for developing and implementing the unique requirements for the Specialty Plan program and population. The Specialty Plan Program Director must be experienced with Medicaid managed care and the Specialty Plan's processes, procedures, information systems, resources, and capabilities. The Specialty Plan Program Director shall serve as the primary contact to the state agency for the Specialty Plan program, and shall collaborate with the state agency (in partnership with other state agencies serving Specialty Plan members) to further develop, implement and improve the Specialty Plan program.

3.3.2 **Specialty Plan Medical Director (part-time)** who shall be a Missouri-licensed, board-certified child psychiatrist who has practiced medicine in the United States, is in good standing with the State Board of Medical Licensure, and has at least three years of child and adolescent behavioral health service experience. The Specialty Plan Medical Director must not have had his/her license revoked or suspended under 20 CSR 2150.2. The Specialty Plan Medical Director shall sign any denial letter required under the Missouri regulation. The Medical Director must have sufficient experience to be determined competent by the health plan's Credentials Committee.

a. The Specialty Plan Medical Director shall be the primary clinical leader of the Specialty Plan and be actively involved in all clinical and quality program components of the Specialty Plan. The Specialty Plan Medical Director may serve in a part-time capacity (no less than .5 full time equivalent), but must dedicate sufficient time to perform required responsibilities and provide after-hours consultation as needed. The Specialty Plan Medical Director shall be responsible for the development of clinical care standards, practice guidelines, and protocols; and shall maintain current medical information pertaining to clinical practice and guidelines for the Specialty Plan. The Specialty Plan Medical Director shall be available to the health plan's medical staff for consultation on referrals, denials, grievances, appeals, and problems.

b. The following health plan staff shall have either a direct or indirect reporting relationship to the Specialty Plan Medical Director: the Specialty Plan Quality Assessment and Improvement Coordinator and the Specialty Plan Care Management Supervisors. The Specialty Plan Medical Director shall ensure compliance with the NCQA, and all federal, state, and local reporting laws on communicable diseases, child abuse, neglect, etc.

3.3.3 **Specialty Plan Quality Assessment and Improvement Coordinator** for the Specialty Plan population shall be a registered nurse, nurse practitioner, qualified mental health professional or physician and licensed in the State of Missouri. The Specialty Plan Quality Assessment and Improvement Coordinator must have formal certification in quality improvement, risk management, or another parallel field. If the person in the position is a physician, the physician must have practiced or must currently practice medicine in the United States. The Specialty Plan Quality Assessment and Improvement Coordinator must have sufficient experience in monitoring and reporting quality metrics, HEDIS measure data collection and reporting, and quality improvement methods and approaches to be determined competent by the Specialty Plan's Medical Director or the Credentials Committee. Certification as a Certified Quality Professional is preferred.

3.3.4 **Specialty Plan Member, Family and Stakeholder Engagement Coordinator** shall be either (1) a Missouri-licensed social worker; (2) a Missouri-licensed registered nurse including an advanced practice nurse, physician, or physician's assistant; or (3) have a Master's degree in health services, public health, or health care administration. The Specialty Plan Member, Family and Stakeholder Engagement Coordinator shall be responsible for engaging Specialty Plan members and their caretakers/families, the state agency, member-serving systems, and other stakeholders to inform and support the design, implementation, and ongoing improvement of the Specialty Plan. These stakeholders and providers include, at a minimum, the state agency, DMH, CD, DYS, FSD, DESE, LPHAs, hospitals, the judicial system, schools, and CMHCs. The Specialty Plan Member, Family and Stakeholder Engagement Coordinator shall be familiar with the variety of services available through the Missouri human services agencies that interface with health care. The Specialty Plan Member, Family, and Stakeholder Engagement Coordinator shall provide timely and comprehensive facilitation of the identification of medically necessary services and implementation of such when included in a Specialty Plan member's IEP/IFSP. The Specialty Plan Member, Family, and Stakeholder Engagement Coordinator shall be the main point of contact for Specialty Plan members, their caretakers/families, providers, the state agencies, and LPHAs.

3.3.5 **Specialty Plan Care Management Supervisors** who shall be fully dedicated to the Specialty Plan population and have the following qualifications, unless otherwise requested and justified by the health plan and approved by the state agency:

a. Specialty Plan Care Management Supervisors must be either a Missouri-licensed Mental Health Clinical Nurse Specialist, a Mental Health Nurse Practitioner, a qualified mental health professional or a Missouri-licensed psychologist in good standing and have appropriate physical and behavioral health knowledge and expertise to support whole person health. Specialty Plan Care Management Supervisors must have experience managing care management programs and staff for specialty populations similar to the Specialty Plan population.

3.3.6 **Pharmacy Director (part-time)** who shall be a registered pharmacist in the state of Missouri with experience in state and federally funded health care programs. The Pharmacy Director may serve in a part-time capacity and may be shared with the health plan, but shall dedicate sufficient time to the Specialty Plan to perform required responsibilities. The Pharmacy Director shall be responsible for monitoring pharmacy utilization; identifying, and addressing outlier prescribing practices; providing pharmacy-related consultation, guidance, and training to Specialty Plan staff and providers; and collaborating with the state agency, CD, DYS, DMH, and the Center for Excellence to fulfill Specialty Plan expectations under Missouri's Psychotropic Medication Settlement and addressing any other prescriber-related concerns for Specialty Plan members in CD's custody.

3.3.7 In addition to the Health Plan Administration Requirements otherwise stated herein, the following Specialty Plan personnel shall be located within and operate from the State of Missouri:

a. Specialty Plan Program Director;
b. Specialty Plan Medical Director;
c. Specialty Plan Quality Assessment and Improvement Coordinator;
d. Specialty Plan Member, Family, and Stakeholder Engagement Coordinator;
e. Specialty Plan Care Management Supervisors; and
f. Pharmacy Director.

3.3.8 In addition to the notification and replacement requirements applicable to the key positions otherwise specified herein, the Specialty Plan shall inform the state agency in writing within seven 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 90 calendar days of the departure of the former staff member.

a. Specialty Plan Program Director;
b. Specialty Plan Medical Director;
c. Specialty Plan Quality Assessment and Improvement Coordinator;
d. Specialty Plan Member, Family, and Stakeholder Engagement Coordinator;
e. Specialty Plan Care Management Supervisors; and
f. Pharmacy Director.

3.3.9 The following personnel, which includes personnel otherwise identified herein, shall have knowledge and experience with the unique needs of populations covered under the Specialty Plan, including the provision of trauma-informed care, care coordination for individuals with multi-system involvement, and treatment of children, adolescents and young adults with complex behavioral and/or medical health needs.

a. Specialty Plan Program Director;
b. Specialty Plan Medical Director;
c. Specialty Plan Quality Assessment and Improvement Coordinator;
d. Specialty Plan Member, Family and Stakeholder Engagement Coordinator;
e. Specialty Plan Care Management Supervisors;
f. Health Plan and Specialty Plan Care Management Staff;
g. Pharmacy Director;
h. Health Plan Utilization Management Coordinator;
i. Health Plan and Specialty Plan Service Authorization Staff; and
j. Health Plan Network Development and Management Director.

3.4 Specialty Plan Provider Network Requirements:

3.4.1 **General** – In addition to the general provider network requirements otherwise specified herein, the Specialty Plan shall:

Addendum 02 added a word to the paragraph below.

a. Develop, monitor, and maintain a comprehensive provider network that meets the unique and complex needs of Specialty Plan members, maximizes the availability of community-based, trauma-informed, and integrated services and reduces any unnecessary utilization of inpatient, emergency services, and out-of-home/out-of-state (hereinafter referred to as OOS) placements. The Specialty Plan shall increase network access to prevention, community-based and specialty providers (e.g., developmental-***behavioral*** pediatricians, trauma therapists and dental/orthodontic specialists) and promote the use of natural and informal supports.

b. Provide training and education to enhance the competencies and skills of network providers to deliver trauma-informed and evidence-based services to Specialty Plan members. The state agency may specify or modify training and education requirements as determined necessary by the state agency.

c. Minimize the disruption and ensure the continuity of care for Specialty Plan members by offering a contract or a single case agreement for a minimum of six months to providers (including OOS placement providers) that have provided treatment to Specialty Plan members prior to implementation of a contract(s) awarded in response to this RFP.

d. Collaborate with the state agency and implement requirements to comply with the Family First Prevention Services Act of 2018 (PL 115-123) and other programs affecting Specialty Plan members.

3.4.2 **Network Development and Monitoring Plan -** The Specialty Plan shall develop and submit a Network Development and Management Plan that meets the requirements otherwise identified herein in "Network Development and Management Plan" and demonstrates that the Specialty Plan maintains a sufficient provider network to meet the needs of its members. In addition, the Specialty Plan's Network Development and Management Plan shall include the following:

a. A summary of the Specialty Plan's provider training and education activities, including those promoting the delivery of trauma-informed and evidence-based services;

b. A summary of the Specialty Plan's strategies for expanding its network of providers with experience and expertise in treating the needs that are common to children and young adults in the Specialty Plan such as abuse, neglect, sexual offender behavior, comorbid complex conditions, and trauma exposure; and

c. An OOS placement summary that includes the number of members placed OOS during the reporting period, a description of the unique needs of the members or circumstances that necessitate placement OOS, and the efforts by the Specialty Plan to develop in-network options.

3.4.3 **PCP Provider Responsibilities -** In addition to the requirements otherwise specified herein in "PCP Responsibilities," when assessing and screening to determine members' medical and behavioral health service needs, the Specialty Plan shall ensure that PCPs assess for the signs, symptoms, and risks of trauma to inform treatment approaches and trauma-informed service needs.

3.4.4 **Behavioral Health Providers -** In addition to the requirements otherwise specified herein in "Behavioral Health Providers," the Specialty Plan shall also include the following behavioral health service providers in its provider network:

a. Comprehensive Community Support Services (hereinafter referred to as CCS) Providers - The Specialty Plan shall include providers in network that deliver CCS services for Specialty Plan members placed in a CD-licensed residential facility, qualified residential treatment program (hereinafter referred to as QRTP,) as set forth in 13 CSR 35-71.160 therapeutic foster home, or as aftercare following the member's discharge from such placements.

a. Practitioners certified in one or more of the following evidence-based practices (EBPs): Eye Movement Desensitization Reprocessing (EMDR), Trauma Focused Cognitive-Behavioral Therapy (TF-CBT), and Dialectical Behavior Therapy (DBT).

3.4.5 **Required Contracts -** The Specialty Plan shall contract with the following providers, unless the Specialty Plan obtains written authorization from the state agency:

a. Medical Homes that specialize in serving children and youth in foster care including, at a minimum, SSM Cardinal Glennon Children's Hospital, Children's Mercy Pediatric Care Network (CMPCN), and Washington University School of Medicine – The SPOT;

1) The Specialty Plan shall not reduce current reimbursement levels for services provided by SSM Cardinal Glennon Children's Hospital, CMPCN, and Washington University School of Medicine – The SPOT unless approved in writing by the state agency.

b. The University of Missouri Psychiatric Center – (MUPC), which specializes in serving the populations enrolled in the Specialty Plan, but not limited to the DYS population.

3.4.6 Non-Participating Providers:

a. Trauma-Informed Care - If the Specialty Plan is unable to provide medically necessary services from a network provider experienced in child-welfare and trauma informed care to address the specific needs of a Specialty Plan member, the Specialty Plan shall cover the services from a non-participating provider for as long as the Specialty Plan's network is unable to provide the services.

b. Psychiatric Residential Treatment Facility (PRTF) and CCS Services - If the Specialty Plan does not have a PRTF or CCS provider in its network that meets service accessibility standards, the Specialty Plan shall cover the services from a non-participating provider for as long as the Specialty Plan's network is unable to provide the services.

c. OOS Placements - In the absence of the availability of an in-state residential placement to meet the needs of a Specialty Plan member, the Specialty Plan shall ensure access to an OOS residential provider and offer a single case agreement to the OOS provider.

3.4.7 Significant Network Changes - In the event of network changes, in addition to complying with the requirements otherwise specified herein in "Significant Network Changes," the Specialty Plan shall notify the state agency of a decrease in the total number of behavioral health professionals by more than 5%.

3.5 Service Accessibility Standard Requirements – In addition to the service accessibility standards otherwise specified herein in "Service Accessibility Standards," the Specialty Plan shall comply with the additional requirements below.

3.5.1 **Certification Review –** In addition to the certification review standards otherwise specified herein in "Certification Review," when performing psychiatric inpatient admission and continued stay reviews, the Specialty Plan shall not deny coverage as a result of a delay in obtaining informed consent for psychotropic medication required by CD policy or the terms of the psychotropic medication settlement agreement. The Specialty Plan shall coordinate with CD case managers and Foster Care Case Management (hereinafter referred to as FCCM) contracted providers to facilitate and expedite obtaining informed consent in a timely manner. The Specialty Plan shall collaborate with CD case managers and FCCM contracted providers to improve the systemic timeliness of obtaining informed consent for psychotropic medications for Specialty Plan members.

3.6 Payments to Providers Requirements - In addition to the payment provisions otherwise specified herein in "Payments to Providers," the Specialty Plan shall make payments to providers as specified below.

3.6.1 To ensure continuity of care, the Specialty Plan shall reimburse providers that continue to deliver services to Specialty Plan members no less than 100% of the current Medicaid fee-for-service rate for the first six months of the contract.

3.6.2 **Fee Schedule for CCS Services** - The Specialty Plan shall reimburse providers of CCS services no less than 100% of the current Medicaid fee-for-service rate.

3.6.3 **MO MAPS -** The Specialty Plan shall reimburse providers participating in the MO MAPS program as otherwise specified herein. This program improves access to primary care services for Managed Care Program participants including those in the Specialty Plan.

3.7 Specialty Plan Benefit Package Requirements:

3.7.1 **General Requirements -** The Specialty Plan benefit package shall be comprised of an array of physical and behavioral health services designed to support the unique and complex needs of Specialty Plan members. The Specialty Plan shall deliver services in a manner that integrates member care; promotes the early identification, prevention, and treatment of health care conditions; addresses member adversity and trauma; encourages the appropriate use of community-based services and resources; and supports resiliency and recovery for members and their families.

3.7.2 **Benefit Package -** In addition to the medical and behavioral health services as otherwise specified herein in "Comprehensive Benefit Package," the Specialty Plan shall cover the following behavioral health services for members enrolled in the Specialty Plan (outlined in the *MO HealthNet Managed Care Policy Statements* located and periodically updated on the state agency Managed Care Program website).

a. **CCS Rehabilitation Services** - Subject to Institution for Mental Disease (IMD) coverage exclusion requirements, CCS rehabilitation services are covered for Specialty Plan members who have behavioral conditions that require rehabilitative services in a CD-licensed residential facility, QRTP as set forth in 13 CSR 35-71.160, or therapeutic foster home, or those who are being discharged from these treatment levels and require comprehensive community support rehabilitation services to maintain treatment outcomes in a less restrictive environment. CCS rehabilitation providers are paid a per diem rate based upon level of treatment need and include the following: Level 2, Level 3, Level 4, Therapeutic Foster Care and Residential Aftercare. CD identifies children in the custody of CD qualifying for these services and approves the provision of CCS rehabilitation based upon CD's determination of the member's level of treatment need. The Specialty Plan is responsible for authorizing Medicaid coverage for CCS rehabilitation services. A *Comprehensive Community Support Billing and Operations Manual* will be provided following contract award.

Addendum 03 revised the subparagraph below.

b. **Non-Emergency Medical Transportation -** The Specialty Plan shall provide non-emergency medical transportation to Specialty Plan members, ***except for those members with ME codes 08, 52, and 57,*** 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 state agency Fee-For-Service covered services not included in the comprehensive benefit package.

Addendum 03 deleted the subparagraph below.

1) DELETED.

3.7.3 **Additional Health Benefits -** In addition to the requirements that apply to additional health benefits as otherwise specified herein in "Additional Health Benefits," the Specialty Plan should be encouraged to consider the unique and complex needs of the Specialty Plan population when selecting additional health benefits. For example, considerations may include sensory-based interventions to address trauma, social determinants of health needs to include benefits such as meal vouchers, backpacks and respite.

3.7.4 **In Lieu of Services or Settings (ILOS).** In addition to the requirements and ILOS as otherwise specified herein in "In Lieu of Services or Settings (ILOS)," the Specialty Plan should be encouraged to offer the ILOS listed below as clinically indicated to members enrolled in the Specialty Plan in anticipation of the state agency requiring future coverage of these services following program implementation through the State Plan and/or waiver options.

a. Partial Hospital Program (PHP) - The Specialty Plan may offer PHP services consistent with the requirements in 42 CFR 410.43 in lieu of psychiatric/substance use inpatient services, PRTF services, or other higher levels of psychiatric/substance use services.

b. Intensive Outpatient Program (IOP) - The Specialty Plan may offer IOP in lieu of psychiatric/substance use inpatient services, PRTF services, or other higher levels of psychiatric/substance use services.

c. Emergency Department and Inpatient Diversion/Stepdown services may be offered in lieu of psychiatric or substance use inpatient care to adults age 21 and older for up to 90 calendar days annually, and for children under the age of 21 with no annual limit.

3.8 Coordination with Services not Included in the Specialty Plan Benefit Package Requirements - In addition to the coordination requirements for services as otherwise specified herein in "Coordination with Services not Included in the Comprehensive Benefit Package," the Specialty Plan shall coordinate the provision of services below that are not included in the Specialty Plan benefit package:

3.8.1 **DYS Rehabilitative Behavioral Health Treatment Services for Institutionalized Youth** - DYS rehabilitative behavioral health treatment services for institutionalized youth shall be reimbursed by the state agency on a fee-for-service basis.

3.9 Member Care Management (CM), Disease Management (DM), Hospital Care Transition (HCT), and Transition of Care (TOC) Requirements:

3.9.1 **Member CM** - The Specialty Plan shall offer and provide CM to all Specialty Plan members with a focus on improving health outcomes and member/family experiences. The Specialty Plan's CM program shall utilize a person-centered, integrated approach to meet the complex physical health, behavioral health and psychosocial needs of Specialty Plan members and their families. CM includes DM, HCT, and TOC.

3.9.2 **General Requirements of Member CM -** The Specialty Plan's CM program shall comply with the following requirements:

a. The Specialty Plan's CM program shall meet the requirements as otherwise specified herein in "Member Care Management (CM), Disease Management (DM), Hospital Care Transition (HCT), and Transition of Care (TOC) Requirements."

b. The Specialty Plan shall serve as the hub for CM services for Specialty Plan members. The Specialty Plan shall support and augment CM activities performed by other entities including, at a minimum, those subcontracted by the Specialty Plan (e.g., medical homes, primary care and CMHC health home providers, LCCCPs, and LPHAs) as necessary to fulfill CM requirements. If the member is not receiving CM from a subcontracted entity, the Specialty Plan shall perform all required CM activities for the member/family.

c. The Specialty Plan shall have processes in place to ensure that CM services provided by the Specialty Plan do not duplicate CM activities performed by its subcontracted CM entities.

d. The Specialty Plan shall closely coordinate with CD and FCCM, DYS, DMH and other entities who may be providing case management activities to ensure that the Specialty Plan's CM program supports, but does not duplicate, activities performed by staff from CD, DYS, and other entities working with members/families/resource providers.

e. The Specialty Plan shall minimize burden for members, families, and resource providers to the greatest extent possible by working with other CM entities to develop shared assessments and care plans, and streamline points of contact to receive assistance in accessing needed services.

f. The Specialty Plan shall have processes in place to monitor CM activities performed by the Specialty Plan and its subcontracted CM entities to ensure CM requirements are met. The Specialty Plan shall employ a quality improvement approach to evaluate and improve the efficiency, effectiveness and outcomes of its CM program for Specialty Plan members.

g. The Specialty Plan shall participate in an annual CM evaluation that is based on the Journey Mapping model. The state agency will provide additional information regarding this model following contract award.

h. The Specialty Plan shall participate in and promote programs that provide consultative services that are beneficial to Specialty Plan members, including, but not limited to consultative services available through the Show-Me ECHO, University of Missouri Psychiatric Center (MUPC), Primary Care and CMHC Health Homes, the Center for Excellence in CHILD Well-Being (CFE), and Missouri's Child Psychiatry Access Project programs.

Addendum 03 inserted the subparagraph below.

i. The health plan shall work with the guardian/foster parents to ensure that the member receives all required examinations and healthcare visits/interventions within the time specified by the State and determined by the child's needs. The health plan shall use the intensified visit schedule for children in foster care in keeping with the American Academy of Pediatrics (AAP) guidelines (https://pediatrics.aappublications.org/content/pediatrics/136/4/e1131.full.pdf and https://pediatrics.aappublications.org/content/136/4/e1142).

3.9.3 **Principles of CM -** The Specialty Plan CM Program must reflect the principles of Member CM as otherwise specified herein in addition to the following principles:

a. Integrated - CM shall identify and address the holistic (physical health, behavioral health, and psychosocial) needs of each member in an integrated manner.

b. Member/Family-centered - CM shall support the individualized goals of the member/family, respecting the member/family's preferences, values, and culture.

c. Trauma Informed - All CM activities, including assessment and care planning shall be provided in accordance with the definition of trauma informed care as otherwise specified herein, incorporating the key principles of the Missouri Model, which are also elaborated elsewhere herein.

d. Well-Coordinated - Specialty Plan members may have multiple individuals and member-serving systems involved in their care and treatment (e.g., parents, foster parents, DYS case managers, CD and contracted case managers, CMHCs/CCBHOs, CSTAR programs, DMH DDD providers, PCPs, other providers, and schools). The Specialty Plan shall communicate and collaborate with natural supports, health care decision-makers, and member-serving systems, as allowed by state and federal law, to develop a common assessment and shared care plan that reflects the member/family's strengths and needs; to coordinate care transitions; to monitor the delivery and effectiveness of care; and to create a seamless experience of care to the greatest extent possible.

3.9.4 **CM Program Plan -** The Specialty Plan must submit a written CM Program plan to the state agency for review and approval as part of readiness review activities prior to implementation of a contract awarded in response to this RFP. On an annual basis thereafter, by July 1 of each year, the Specialty Plan shall submit a written evaluation of its CM Program, along with any proposed modifications to its CM Program plan. The written evaluation must describe how the Specialty Plan met CM requirements during the reporting period; the effectiveness of the CM Program to achieve desired CM outcomes (improving health outcomes and member/family experience); opportunities for CM Program improvement; and actions taken by the Specialty Plan to implement CM Program improvements. The Specialty Plan's CM Program plan must describe the following CM components:

a. Staffing - The CM program staffing serving special plan members, including the number of staff, roles, and qualifications;

b. Training - The required CM staff training, by topic, and frequency;

c. CM tiers - The Specialty Plan's CM tiers, criteria, and threshold for each tier, and the risk stratification process;

d. CM assignment - The Specialty Plan assignment of qualified CM staff, proposed caseload size for each tier, assignment methodology, contact schedule and process for members/families/resource providers, and providers and/or member-serving systems to request an assignment for a higher CM tier;

e. CM coordination and accountability - The respective roles and responsibilities of Specialty Plan CM program to ensure member needs are met both when the Specialty Plan is exclusively providing CM and when the Specialty Plan is supporting other subcontracted entities performing CM activities;

f. Disease management approach - The Specialty Plan's approach to disease management within its CM program;

g. CM information systems and analytics - The Specialty Plan's information systems and analytics, the type of data and information that will be collected to support the Specialty Plan's CM program, and how the Specialty Plan will use the information systems and analytics to support CM program activities; and

h. CM Monitoring - The Specialty Plan's approach to monitoring CM services provided by the Specialty Plan and/or its subcontracted entities performing CM activities to ensure CM that supports optimal individual outcomes and CM program operational excellence.

3.9.5 **CM Program Staffing Requirements -** Specialty Plan CM staff shall be composed of individuals with diverse specialties and experience necessary to capably deliver comprehensive, integrated CM services to meet the physical, behavioral, and psychosocial needs of Specialty Plan members.

3.9.6 **CM Training -** The Specialty Plan shall provide CM staff onboarding and ongoing training necessary for staff to perform their job responsibilities. Training topics for CM staff must include the following:

a. An overview of the respective roles and responsibilities of the Specialty Plan, member-serving entities (e.g., the state agency, DYS, DMH, CD and CD-contracted case management providers), and Specialty Plan subcontracted entities that perform CM activities;

b. An overview of the Specialty Plan's CM program and CM responsibilities;

c. Trauma-informed care and other evidence based and promising practices applicable to Specialty Plan members;

d. Covered benefits for Specialty Plan members and Specialty Plan network providers;

e. Informed consent, assent, and alternative consenter requirements that apply to Specialty Plan members in the legal custody of CD;

f. Social determinants of health and available community services and resources;

g. Specialty Plan information systems, operational processes and workflows;

h. Missouri's Psychotropic Medication Settlement (https://dss.mo.gov/notice-of-proposed-class-action-settlement.htm), the related responsibilities of the Specialty Plan, and the role of the Center for Excellence;

i. DYS and CD specific resources available to or in support of the member (e.g., MUPC, child welfare prevention, Missouri's Child Psychiatry Access Project, the Center for Excellence in CHILD Well-Being CFE, and county-specific resources); and

j. DYS and CD residential programs, levels of care, and services.

3.9.7 **CM Tiers -** The Specialty Plan shall establish CM tiers to align with the level of CM needed by the member, the criteria and threshold for each tier, and the stratification process used to assign members to tiers. Health risk factors when determining a member's tier level shall include, at a minimum, the following:

a. Information from the enrollment broker's health risk assessment screening;
b. Acuity, chronicity, and complexity of the member's physical and behavioral health conditions;
c. Comorbidities;
d. Trauma history;
e. Pregnancy and related risk factors;
f. Multi-system involvement;
g. Polypharmacy;
h. Psychotropic medication prescription(s);
i. Elevated blood lead levels;
j. High-cost and high-utilization;
k. Residential placement; and
l. Psychosocial needs (e.g., consideration of needs related to social determinants of health).

3.9.8 **CM Assignment.** All Specialty Plan members are eligible for CM and shall be assigned by the Specialty Plan to a CM tier.

a. Upon enrollment, the Specialty Plan shall stratify and assign members to an appropriate CM tier based upon the Specialty Plan's state agency-approved criteria and thresholds.

b. The Specialty Plan shall perform an initial CM and disease management assessment within 14 calendar days of enrollment to identify the appropriate CM tier level and presenting issues necessary to start the formulation of the member's care plan.

c. The Specialty Plan shall re-evaluate a member's tier assignment whenever there is a significant change in the member's needs or risk factors, but no less than annually. Examples include an admission to an inpatient behavioral health setting, a newly diagnosed condition, a change in service utilization levels, and the prescription of a psychotropic medication or newly identified psychosocial need.

d. The Specialty Plan's assignment methodology must consider the CM staff qualifications, experience, acuity mix, and the member's cultural and linguistic needs.

e. The Specialty Plan shall communicate the member's tier assignment and Specialty Plan CM contact information to members/families/resource providers, the member's PCP, and all entities involved in performing CM activities and care planning.

f. The Specialty Plan shall allow and consider requests from a member/family/ resource provider, or a member-serving system to assign the member to a higher intensity tier of CM services.

g. The Specialty Plan shall provide outreach to members/families/resource providers to engage in CM. The Specialty Plan shall not terminate or close CM services for Specialty Plan members/families/resource providers who do not respond to outreach attempts, do not engage in CM, or refuse CM services; however, the Specialty Plan may assign members in those circumstances to the lowest intensity level of CM services. The Specialty Plan shall make reasonable outreach efforts prior to changing a member's tier to the lowest intensity level.

1) "Reasonable efforts" means either the member/family/resource provider has refused CM services or the Specialty Plan has made at least three different types of unsuccessful contact attempts. For members in the legal custody of CD, prior to changing a member's tier level to the lowest intensity level, the Specialty Plan shall contact the member's CD case manager or FCCM case manager.

2) Examples of types of contact attempts include those otherwise specified elsewhere herein in "Hospital Care Transition (HCT) Management." The Specialty Plan shall document contact attempts and CM refusals in the care plan.

3.9.9 **CM Coordination and Accountability -** The Specialty Plan shall have primary accountability to ensure the CM needs of its Specialty Plan members are met. This includes when members receive CM services from the Specialty Plan, Specialty Plan-subcontracted entities, or in cases in which there may be more than one person performing CM activities. Specific examples include the following:

a. Medical Homes - Medical homes are models of primary care that are comprehensive, patient-centered, coordinated, accessible, and focused on quality and safety (as defined by The Agency for Healthcare Research and Quality). The Specialty Plan shall establish respective CM roles and responsibilities between the Specialty Plan and medical homes for members receiving CM services from medical homes.

b. DYS and CD Case Management - The Specialty Plan shall collaborate with the state agency, DYS, CD, and FCCM agencies to define and implement CM roles and responsibilities of the Specialty Plan care managers, DYS case managers, CD case managers, and FCCM case managers.

c. Coordination with Primary Care Health Homes and CMHC Health Homes - The Specialty Plan shall comply with requirements as otherwise specified herein in "Coordination with Primary Care Health Homes and CMHC Health Homes" for Specialty Plan members in primary care and CMHC health homes.

d. HCT Management - The Specialty Plan shall comply with requirements as otherwise specified herein in "Hospital Care Transition (HCT) Management." In addition, when developing a plan with the hospital to facilitate the transition of care for members, the Specialty Plan shall include participation and input from entities responsible for performing CM activities for the member.

3.9.10 **CM Activities -** The Specialty Plan shall ensure members have access to the following CM services, whether the Specialty Plan directly performs these activities or ensure subcontracted entity performance of the following CM activities:

a. Outreaching to members/families/resource providers to engage in care coordination;

b. Conducting or arranging for member assessments as needed;

c. Offering health education, DM, and wellness/prevention coaching;

d. Facilitating case conferences and developing multidisciplinary, shared care plans that include crisis/safety plans as appropriate;

e. Educating providers about resources available through Missouri's Child Psychiatry Access Project, MUPC, the Center for Excellence in CHILD Well-Being, and regional/county-specific child welfare and juvenile resources;

f. Coordinating member access to services and resources identified in the care plan, including securing necessary authorizations and identifying network providers to deliver services;

g. Educating members/families/resource providers about covered benefits and screening/referring members/families/resource providers to community resources for psychosocial (social determinants of health) needs;

h. Collaborating, communicating, and exchanging information with PCPs, providers, and other member-serving entities, as permitted by state and federal law, to coordinate member care;

i. Coordinating services that are not included in the Specialty Plan's comprehensive benefit package, but are covered by other member-serving entities, as otherwise specified herein in "Coordination with Services Not Included in the Comprehensive Benefit Package," such as Behavioral Health Community Psychiatric Rehabilitation (BH CPR), Applied Behavior Analysis (ABA), Developmental Disabilities (DD) waiver, Comprehensive Substance Treatment and Rehabilitation (C-STAR), pharmacy, and school-based services;

j. Ensuring members receive services needed for permanency planning;

k. Monitoring to ensure that care plan services are delivered and the effectiveness of services;

l. Participating in discharge planning activities to prevent unnecessary readmissions, emergency room visits, and other adverse outcomes; and

m. Facilitating transitions of member care.

3.9.11 **Disease Management Approach -** The Specialty Plan shall comply with disease management approach requirements as otherwise specified herein in "Member Care Management (CM)."

3.9.12 **CM Information Systems and Analytics -** The Specialty Plan shall provide CM information systems and analytic capabilities that collect, integrate, and share pertinent CM information necessary to support CM program responsibilities.

a. The Specialty Plan's information system shall have the capabilities to share access to the member's care plan with the member/family/resource providers, assigned case manager, Health Information Specialist (HIS), PCP, and providers involved in the members' care and treatment, in compliance with state and federal law.

b. The Specialty Plan's systems and analytics shall have the capabilities to inform and monitor CM on individual (e.g., member-specific utilization data and patterns, readmissions, and incidents) and systemic (e.g., aggregate outcomes, timeliness of CM services, network gaps) levels.

3.9.13 **CM Monitoring -** The Specialty Plan shall self-monitor and monitor subcontracted entities performing CM activities to ensure CM needs of individual members are met and systemically assess CM quality, effectiveness, and compliance. Upon the identification of unmet member needs or systemic deficiencies, the Specialty Plan shall take the necessary actions to remediate the unmet needs/deficiencies.

3.9.14 **CM Record Documentation -** The Specialty Plan shall comply with CM record documentation as otherwise specified herein. In addition, the Specialty Plan shall document Specialty Plan-subcontracted entities or other persons performing CM activities.

3.9.15 **CM Policy Requirements -** The Specialty Plan shall comply with CM policy requirements as otherwise specified herein. In addition the Specialty Plan's CM policies and procedures shall address the following:

a. Care Plans - Care plans for Specialty Plan members must be updated at least quarterly and following every member/family touch, provider interaction, within ten calendar days of discharge from an inpatient state or emergency room visit, and any other pertinent event. The Specialty Plan shall provide a copy of the care plan to CD using a state-determined method.

b. Assent, Informed Consent, and Alternative Consenters - Assent, informed consent and alternative consenter requirements apply to Specialty Plan members in the legal custody of CD. The Specialty Plan shall work with the state agency and CD as part of readiness activities to develop policies and procedures that operationalize requirements related to assent for members 12 and older, informed consent, and alternative consenters. Considerations for these policies and procedures should include, at a minimum, timely access to medical records to support informed consent decisions when applicable; resources/support for CD and FCCM case managers to facilitate understanding of medications prescribed, including coordination of roles of Specialty Plan and Center for Excellence in Child Well-Being to support informed consent; and Specialty Plan participation in calls between CD/FCCM case managers and foster and/or biological parents when applicable. Please visit the following link for definitions of these terms: https://dssmanuals.mo.gov/child-welfare-manual/section-4-chapter-4-working-with-children-subsection-3-medical-and-mental-health-planning/.

c. Coordination of other formal and informal CM entities and activities.

d. DM - The Specialty Plan shall develop policies and procedures that reflect how the Specialty Plan operationalizes requirements as otherwise specified herein in "Disease Management Approach."

e. TOC - The Specialty Plan shall develop policies and procedures that reflect how the Specialty Plan operationalizes requirements as otherwise specified herein in "Member Transition of Care."

3.9.16 **Member Transition of Care -** In addition to the requirements as otherwise specified herein in "Transition of Care," the Specialty Plan shall comply with the following transition of care requirements:

a. Member Transitions upon Contract Implementation - The Specialty Plan shall ensure continuity of care for Specialty Plan members. The Specialty Plan shall continue medically necessary services without any form of prior approval and without regard to whether such services are provided by in-network or out-of-network providers. The Specialty Plan shall continue services as such for at least six months unless the member/family has opted to discontinue such services or select a provider that is in-network.

1) TOC requirements as otherwise specified herein, apply to member transitions between a health plan and the Specialty Plan.

2) Age/Eligibility Transitions - The Specialty Plan shall anticipate and assist members/families/resource providers for critical age transitions, including pediatric/child to adult transitions and transitions required as a result of aging out or loss of Specialty Plan eligibility. Through the construct of the Specialty Plan's CM program, the Specialty Plan shall ensure that Specialty Plan members/families/resource providers, CD, and contracted case managers are educated and offered assistance in planning for age transitions at least six months prior to critical age transitions. The Specialty Plan shall ensure members and their families are provided the necessary information to inform choices when making transition-related decisions due to aging out or losing Specialty Plan eligibility. In addition to health care coverage and coordination, discussions related to legal considerations (e.g., the need for guardianship or conservatorship in the event of the incapacity or disability of the member), financial needs, employment, education, living arrangements, and social needs should be part of transition planning as applicable. The Specialty Plan's assistance shall support/complement and not duplicate/conflict with CD, DYS, and DMH

3.10 Eligibility, Enrollment, and Disenrollment Requirements:

3.10.1 The requirements in Section 2.13: "Eligibility, Enrollment, and Disenrollment" apply to the Specialty Plan unless otherwise indicated herein. In the event there is a conflict of requirements between provisions herein and the requirements in 2.13, the provisions herein shall control.

3.10.2 Automatic Assignment into Health Plan:

a. Children in the care and custody of the state and receiving adoption subsidy assistance as otherwise specified herein, shall be automatically assigned to the Specialty Plan on the date the child's eligibility is entered.

b. There shall be no option for a member to choose a different health plan.

c. If a participant in the Specialty Plan loses their eligibility for this eligibility category, the participant shall be automatically assigned to the General Plan administered by the same health plan that administers the Specialty Plan. At that time, the participant will have the option to choose a different General Plan within 90 calendar days.

d. Newborns born to mothers who are not in the Specialty Plan, but are in state care and custody shall be automatically assigned to the Specialty Plan.

3.10.3 **Provider Directory -** The Specialty Plan shall make available on its website, an up-to-date, searchable provider directory of Specialty Plan network providers available to Specialty Plan members. The Specialty Plan provider directory shall comply with the provider directory requirements as otherwise specified herein in "Provider Directory."

3.11 Member Education Requirements:

3.11.1 The Specialty Plan shall provide member education to their members in accordance with the requirements as otherwise specified herein.

3.12 Member Services Requirements:

3.12.1 The Specialty Plan shall provide all member services as otherwise specified herein. In addition, the Specialty Plan shall have and implement member services policies and procedures that address all member services activities as otherwise specified herein.

3.1.2 The member services that are provided through the Specialty Plan shall be provided through a dedicated member website and member portal.

3.13 Member, Family and Stakeholder Advisory Council Requirements:

3.13.1 The Specialty Plan shall develop a Member, Family and Stakeholder Advisory Council (hereinafter referred to as the Council) to obtain meaningful input and recommendations for purposes of improving access to quality care, health outcomes and member/family satisfaction. The Specialty Plan shall convene the Council at least quarterly, offering alternatives to in person meeting attendance such as by telephone or an alternative conferencing modality (e.g., WebEx, Skype, Zoom, Teams).

3.13.2 The Specialty Plan shall ensure the composition of the Council is diverse and includes member and family (i.e., parent, foster parent, guardian) representation, as well as key stakeholders identified by the Specialty Plan and the state agency. The Specialty Plan must include representatives from CD and DYS as key stakeholders, and invite the state agency to attend Council meetings.

3.13.3 The Specialty Plan shall facilitate Council meetings and engage Council participants to elicit meaningful input in areas that include member and family experience; Specialty Plan program strengths and challenges; and opportunities to improve the quality of the Specialty Plan program.

3.13.4 The Specialty Plan shall maintain documentation of Council activities including meeting dates, agendas, minutes and attendees; recommendations from the Council; and the Specialty Plan's response to or implementation of the Council's recommendations.

3.14 Provider Services Requirements:

a. The Specialty Plan shall provide all provider services as otherwise specified described herein. The Specialty Plan shall also have and implement policies and procedures that address all provider services activities. In addition to the requirements otherwise specified herein, the Specialty Plan's provider services staff shall be responsible for education, training, and technical assistance in the following areas:

1) Trauma-informed care;
2) Prescribing practices (as needed to complement and support the work of the Center for Excellence);
3) Needs of Specialty Plan population and service array, including placement options; and
4) Roles/responsibilities of Specialty Plan and partner agencies.

b. Call center staff as otherwise specified herein shall be knowledgeable about the Specialty Plan requirements.

c. The website for providers, as otherwise specified herein shall clearly distinguish any unique provider requirements for the Specialty Plan.

d. The Specialty Plan shall develop, distribute, and maintain a separate provider manual or may use the same provider manual as the General Plan, so long as unique specialty requirements are clear.

3.15 Quality Assessment and Improvement Requirements – The requirements otherwise specified herein in "Quality Assessment and Improvement" apply to the Specialty Plan, unless otherwise indicated herein. In the event there is a conflict of requirements between provisions herein and the requirements otherwise specified herein, the provisions herein shall control.

3.15.1 **Quality Assessment and Improvement Program -** The Specialty Plan shall develop and implement its own Quality Assessment and Improvement Program subject to state agency approval that adheres to state agency requirements and defines practice guidelines; internal quality assessment and improvement program strategies and procedures; performance metrics; and separate data collection, monitoring and reporting of quality metrics for Specialty Plan members and program requirements. The Specialty Plan shall consider feedback and recommendations from the Council to inform its Quality Assessment and Improvement Program and related activities.

3.15.2 **Quality Assessment Committee -** The Specialty Plan shall have a dedicated quality assessment committee, which shall report quality activities and outcomes to the health plan's Quality Assessment Committee. The Specialty Plan Medical Director shall serve as the chairperson for the Specialty Plan's Quality Assessment Committee and include the Specialty Plan's Utilization Manager Coordinator.

3.15.3 **Stakeholder Input -** In addition to obtaining input from the stakeholders as otherwise specified herein to inform quality assessment and improvement efforts, the state agency will obtain input from the Specialty Plan's Member and Family Advisory Council and the CD Health Care Oversight Committee.

3.15.4 **Internal Staff -** The Specialty Plan shall designate a Specialty Plan Quality Assessment and Improvement Coordinator dedicated to perform the activities and responsibilities as otherwise specified herein in "Internal Staff."

3.15.5 **Clinical Practice Guidelines -** In addition to the requirements as otherwise specified herein in "Practice Guidelines," the Specialty Plan shall adopt clinical practice guidelines that consider the unique needs of Specialty Plan members.

3.15.6 **Performance Improvement Projects -** The Specialty Plan shall conduct one clinical or non-clinical PIP as otherwise specified herein in "Performance Improvement Projects." However, the Specialty Plan may select their full Medicaid population or the Specialty Plan population as the focus of the PIP. The Specialty Plan must clearly specify which population their PIP will focus on in their aim statement. The state agency will only require a total of two PIPs of the health plan that is awarded the Specialty Plan and General Plan.

3.16 Financial Data Reporting Requirements:

3.16.1 The Specialty Plan shall submit financial data as otherwise specified herein in "Financial Data Reporting" separately for the Specialty Plan and shall use the Specialty Plan reporting templates located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

3.17 Operational Data Reporting Requirements:

3.17.1 The Specialty Plan shall report operational data as otherwise specified herein in "Operational Data Reporting" separately for the Specialty Plan unless otherwise indicated below or directed in writing by the state agency. The Specialty Plan must also report additional operational data as specified below or directed in writing by the state agency.

3.17.2 **Quality Assessment and Improvement Evaluation Reports -** The quality assessment and improvement evaluation reporting requirements shall include those as otherwise specified herein in "Quality Assessment and Improvement Evaluation Reports," to apply to the Specialty Plan with the following modifications:

Addendum 02 revised the subparagraph below.

a. HEDIS Measures - At a minimum, the Specialty Plan shall report on the following HEDIS measures specific to the Specialty Plan members: Annual Dental Visits (***ADV***); Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (***FUA***); Follow-up After Emergency Department Visit for Mental Illness (***FUH***); Metabolic Monitoring for Children and Adolescents on Antipsychotics (***APM***); Childhood Immunization Status (***CIS***); Lead Screening in Children ***(LSC)***; Weight Assessment and Counselling for Nutrition and Physical Activity for Children/Adolescents (***WCC***); Asthma Medication Ratio (***AMR***); Well-Child Visits in First ***30*** Months of Life (***W30***); and Child & Adolescent Well-Care Visits (***WCV***). Any HEDIS measures reported using the Administrative method must be reported separately by region. Measures using the Hybrid method must be reported with statewide results. The Specialty Plan shall report HEDIS certified results on the annual *Healthcare Quality Data Template* located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates. HEDIS measures are subject to change by the state agency and CMS.

b. Non-HEDIS Quality Metrics - At a minimum, the Specialty Plan shall report the non-HEDIS quality metrics below to the state agency semi-annually. The Specialty Plan shall calculate the quality metrics and format reporting as specified by the state agency.

1) Average length of stay in hospitals (excluding mental health facilities);

2) Average length of stay in a mental health facility;

3) Count of members that had a 30-day comprehensive evaluation completed, including screening for social and emotional needs. The report must be broken down by counts for less than or equal to 30 calendar days and greater than 30 calendar days;

4) Number of enrolled providers the Specialty Plan is contracted with that are certified in an evidence-based practice that addresses trauma.

c. The Specialty Plan shall calculate a baseline measurement of the HEDIS measures and non-HEDIS quality metrics based upon performance in the first year of the contract. Performance during the baseline measurement period will not be subject to withhold or sanction, but may be subject to a corrective action plan. After the baseline measurement period, the state agency may tie Specialty Plan performance on quality measures to withholds, incentives, or sanctions.

d. Following the baseline measurement year, the Specialty Plan shall set HEDIS measure performance goals each year to either achieve the 50th percentile of the NCQA Quality Compass or improve by at least two percentage points. If the Specialty Plan is unable to achieve the performance goal, the Specialty Plan shall provide a written report to the state agency explaining the interventions they implemented during the previous year, why the interventions did not result in achieving the performance goal, and a plan of action detailing the changes the Specialty Plan will implement to improve HEDIS results for the next year.

e. Appointment Availability Report - The Specialty Plan shall submit an annual quality report to the state agency detailing the Specialty Plan's performance in meeting appointment availability times. The Specialty Plan may subcontract the development of the report to a survey company, conduct mailing campaigns, or develop its own method to evaluate this metric. The Specialty Plan's report shall minimally describe the process the Specialty Plan used to accurately evaluate performance, identify barriers and improvement opportunities to meet appointment availability requirements, and outline provider incentive plan initiatives and related findings.

f. Provider Incentive Plans - The Specialty Plan shall submit an annual summary of all incentive plans conducted over the prior year that includes data to support successes or failures. If targets are not achieved, the report shall include steps the Specialty Plan is taking to improve the incentive program or retire it.

3.18 **Risk Mitigation, Performance Withhold Program, and Remedies for Violation, Breach, or Non-Compliance of Contract Requirements** - The requirements as otherwise specified herein in "Risk Mitigation, Performance Withhold Program, and Remedies for Violation, Breach, or Non-Compliance of Contract Requirements" apply to the Specialty Plan with the following exceptions and modifications:

3.18.1 The risk adjustment requirements as otherwise specified herein in "Risk Adjusted Rate" do not apply to the Specialty Plan.

3.18.2 The performance withhold program requirements as otherwise specified herein in "Performance Withhold Program" do not apply to the Specialty Plan. The Specialty Plan shall participate in alternative payment methodologies designed by the state agency that reward quality outcome metrics specific to the Specialty Plan program.

3.18.3 The Specialty Plan shall report MLR data as otherwise specified herein in "Minimum Medical Loss Ratio Requirements" separately for the Specialty Plan and shall use the *Specialty Plan Medical Loss Ratio Template and Instructions* located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and templates.

3.19 Advance Directive Requirements:

3.19.1 In addition to the requirements as otherwise specified herein in "Advance Directives," the Specialty Plan's written policies and procedures shall include providing information to transition-aged youth, adult Specialty Plan members, and their parents/guardians about their ability to execute psychiatric advance directives pursuant to Section 404.800 RSMo, the Durable Power of Attorney for Health Care Act.

3.20 Payment Requirements - The payment requirements as otherwise specified herein in "Payment Requirements" apply to the Specialty Plan, except as follows:

3.20.1 The regional pricing pages and risk adjustment requirements as otherwise specified herein do not apply to the Specialty Plan.

3.20.2 The state agency is in the process of reviewing current providers of CCS rehabilitation services to determine whether the facility should be classified as an IMD. Additionally, the state agency is reviewing which facilities may quality for the QRTP designation. The draft Specialty Plan capitation rates as otherwise specified herein reflect an assumption that providers of CCS services are not classified as IMDs (and thus are eligible for federal financial participation); to the extent this changes based on the stage agency's review, the capitation rates and anticipated COA 4 CCS service utilization will need to be updated accordingly. In addition, the draft Specialty Plan capitation rates do not reflect that some CCS providers may qualify for QRTP designation and therefore may be paid at higher QRTP rates. Following the outcome of the state agency's review, the state agency anticipates the need to adjust the Specialty Plan's capitation rates to reflect updated rate assumptions.

3.21 Medical Records Requirements - In addition to the requirements as otherwise specified herein in "Medical Records," the Specialty Plan shall provide the CD or FCCM case manager with access to members' medical records, whether electronic or paper, within ten business days of receipt of written request at no charge when such request is necessary for the completion of automatic secondary reviews triggered by the criteria set forth in Sections III.D.4.a-b of the Psychotropic Medication Settlement Agreement (https://dss.mo.gov/docs/settlment-2019/joint-settlement-agreement.pdf).

3.22 **Pending Issues Requirements -** The following are pending issues that may be resolved after this RFP is released, after the contract is awarded, or during the term of the contract. The pending issues in this section are subject to change and should not be considered all-inclusive. Additionally, the state agency and the Specialty Plan are subject to mandated statutory, regulatory, judicial, and executive changes related to any term a contract(s) awarded in response to this RFP that may result in changes to the program requirements. Following the resolution of the pending issues or program changes precipitated by statutory, regulatory, judicial, and/or executive mandates, the state agency will reflect changes to program requirements in future amendments to the contract. The state agency may also adjust capitation rates when changes to program requirements impact rate assumptions.

3.22.1 **CCS Rehabilitation Providers and Specialty Plan Capitation Rates -** The state agency is in the process of reviewing the character of current providers of CCS rehabilitation services to determine whether the facility should be classified as an IMD. Additionally, the state agency is reviewing which facilities may quality for QRTP designation. Pending the outcome of the state's review, the draft Specialty Plan capitation rates as otherwise specified herein reflect an assumption that providers of CCS services are not classified as IMDs (and thus are eligible for federal financial participation (FFP)). In addition, the draft Specialty Plan capitation rates do not reflect that some CCS providers may qualify for QRTP designation, and therefore may be paid at higher QRTP rates. Following the outcome of the state agency's review, the state agency will determine if adjustments to the Specialty Plan's capitation rates are necessary.

3.22.2 **Family First Prevention Services Act (hereinafter referred to the FFPSA) of 2018 -** DSS, in collaboration with community partners, state agencies, and other stakeholders across the state, is in the process of implementing changes under the FFPSA, which is designed to increase access to necessary supports to ensure children grow up in safe, healthy homes where families have meaningful access to needed community resources. Changes under the FFPSA may require changes to terms in a contract(s) awarded in response to this RFP. The Specialty Plan will be required to comply with the changes to terms to a contract(s) awarded in response to this RFP as a result of the state's implementation of the FFPSA.

4. CONTRACTUAL REQUIREMENTS

This section of the RFP includes contractual requirements and provisions that will govern the contract after RFP award. The contents of this section include mandatory provisions that must be adhered to by the state and the health plan unless changed by a contract amendment. Response to this section by the vendor is not necessary as all provisions are mandatory.

4.1 Terminology:

4.1.1 All references to the term "contractor" as used in this section and in the Terms and Conditions of this document shall hereto have the same meaning as the term "health plan" and "Specialty Plan".

4.2 Contract:

4.2.1 A binding contract shall consist of: (1) the RFP, addendums thereto, and any Best and Final Offer (BAFO) request(s) with RFP changes/additions, (2) the health plan's proposal including any contractor BAFO response(s), (3) clarification of the proposal, if any, and (4) the Division of Purchasing'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.

a. 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 contractor at the discretion of the state agency.

b. The contract expresses the complete agreement of the parties and performance shall be governed solely by the specifications and requirements contained therein.

    1) The State of Missouri does not negotiate contracts after award.

c. 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 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.

4.3 Contract Period:

4.3.1 The original contract period shall be as stated on the Notice of Award. 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 shall have the right, at its sole option, to renew the contract for four additional one-year periods, or any portion thereof. In the event the Division of Purchasing exercises such right, all terms and conditions, requirements and specifications of the contract, shall remain the same and apply during renewal periods.

4.4 Renewal Periods:

4.4.1 If the option for renewal is exercised by the Division of Purchasing, the health plan shall agree that the prices for the renewal periods shall not exceed the maximum prices for the applicable renewal period stated on the Pricing Pages of the contract.

a. 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 upon 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.

b. If the State of Missouri elects to renew the contract for the first, second, third, or fourth renewal options, the health plan shall accept the amount appropriated by the Governor and the Missouri General Assembly within the actuarially sound capitation rate ranges required by 42 CFR 438.4 to be paid on a risk-based, capitated rate basis. Rates will be actuarially determined for each contract renewal period using a full data rebase methodology in renewal years one and three and an update methodology for trend and program changes in renewal years two and four. At the discretion of the state agency, a full data rebase or updated methodology may be utilized in any renewal year as needed and in compliance with CMS rate development guidance.

4.5 Contract Extension:

4.5.1 The Division of Purchasing shall have the right, at its sole option, to extend the contract as necessary if it is determined to be in the best interest of the state. In the event the Division of Purchasing exercises such right, all other terms and conditions, requirements, and specifications of the contract, including prices (if specified by the state agency), shall remain the same and shall apply during the extension period.

4.6 Contract Price:

4.6.1 All prices shall be firm, fixed, and as indicated on the Pricing Pages. Except as set forth below, 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.

4.7 Termination:

4.7.1 The Division of Purchasing 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 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, 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.

4.8 Transition:

4.8.1 The health plan shall work with the state agency and any other organizations designated by the state agency to ensure an orderly transition of services and responsibilities under the contract and to ensure the continuity of those services required by the state agency.

4.8.2 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:

a. 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 seven calendar days after receipt of the written request in a format and condition that are acceptable to the state agency.

b. The health plan shall discontinue providing service or accepting new assignments under the terms of the contract, on the date specified by the state agency, in order to ensure the completion of such service prior to the expiration of the contract.

c. The health plan shall not accept any new clients on behalf of the state agency nor be paid for service to any new clients by the state agency if service is implemented after the termination or cancellation date of the contract. In the event that services for a client are referred or transferred to another organization, the health plan shall furnish all records, treatment plans, and recommendations, which are necessary to ensure continuity and consistency of care for the client.

d. If requested in writing via formal contract amendment, 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 90 calendar days after the expiration, termination, or cancellation date of the contract for a price not to exceed those prices set forth in the contract.

1) The health plan must obtain specific written approval from the state agency prior to providing continuing services to any client after the termination or cancellation of the contract. The written approval must identify the specific client and contain a date for the termination of service for the client.

2) The decision to allow a client to receive continuing services shall be made by the state agency on a case-by-case basis, at its sole discretion.

4.9 Contractor Liability:

4.9.1 The health plan shall be responsible for any and all tort or statutory liability to third-parties (including, but not limited to, the health plan's agents, employees, and subcontractors) arising out of the health plan's provision of any equipment or services under the contract. In addition, the health plan agrees to defend and indemnify the State of Missouri, it agencies, employees, and assignees from and against all such liability.

a. The health plan also agrees to indemnify, defend, and hold harmless the State of Missouri, its agencies, employees, and assignees from and against any and all tort or statutory liability arising out of the provision of any equipment or services by any subcontractor or other person employed by or under the supervision of the health plan under the terms of the contract.

b. The health plan shall not be responsible for any injury or damage occurring solely as a result of any negligent act or omission by the State of Missouri, its agencies, employees, or assignees.

c. The health plan shall not be responsible for any of the following: (1) third party claims against the State of Missouri for losses or damages except as described above (2) consequential damages (including lost profits or savings), even if the health plan is informed of their possibility.

4.9.2 The health plan shall understand and agree that pursuant to the Constitution of the State of Missouri, Article III, Section 39 the state shall not indemnify, hold harmless, or agree in advance to defend any person or entity.

4.10 Insurance:

4.10.1 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 must acquire and 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 such loss, damage and/or expense related to his/her performance under the contract. General and other non-professional liability insurance shall include an endorsement that adds the State of Missouri as an additional insured. In the event any insurance coverage is canceled, the state agency must be notified at least 30 calendar days prior to such cancelation.

a. Insurance coverage shall include, at a minimum, general liability, and appropriate 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 $2,000,000.00 per occurrence.

b. Written evidence of the insurance shall be provided by the health plan to the state agency prior to performance under the contract. Evidence of insurance shall include, at a minimum, 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.

4.11 Subcontractors:

4.11.1 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.

a. The health plan shall expressly understand and agree that he/she shall assume and be solely responsible for all legal and financial responsibilities related to the execution of a subcontract.

b. The health plan shall understand and agree 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.

c. 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.

d. 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:

1) The direct subcontractor is not knowingly in violation of subsection 1 of Section 285.530, RSMo, and shall not henceforth be in such violation.

2) 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.

4.11.2 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 state agency, and its officers, employees, and agents, and enrolled Managed Care Program members from any and all actions, claims, demands, 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, at a minimum, any negligent or wrongful acts, occurrence, or omission of commission, or negligence of the health plan, its subcontractors, agents, providers, or employees.

4.11.3 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 the 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 or any information necessary for the health plan to perform any of its obligations under the contract including, at a minimum, compliance with all reporting requirements (e.g. 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 form the health plan as payment in full (no balance) 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 that the health plan may 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; and

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 a Medicaid assistance category not included in the Managed Care Program;

2) Requiring or encouraging the member 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 filing out health plan enrollment forms;

5) Photocopying black health plan enrollment forms for potential members;

6) Distributing blank health plan enrollment forms;

7) Participating in three-way calls to the Managed Care enrollment helpline;

8) Suggesting a member transfer to another health plan; and/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 FQHC or a RHC to provide services to members under a prepayment arrangement, a provision that the state agency shall reimburse the FQHC or RHC 100% of its reasonable costs 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 FSD of the birth.

m. For contracted services, the subcontractor shall follow the claim processing requirements set forth by Sections 376.383 and 376.384, RSMo 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 a reasonable timely filing requirement for claims to be filed by a provider for reimbursement. The subcontractor shall inform its provider network if the timely filing requirements.

q. 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.

r. In the case of services provided by out-of-network providers, the health plan shall comply with state law regarding timely filing requirements.

s. In the case of timely filing requirements, the first claim processed, whether paid or denied, should meet these guidelines.

t. Provision for revoking the subcontract agreement or imposing other sanctions if the subcontractor's performance is inadequate.

u. The health plan shall understand and agree that consumer protection shall be integral to the Managed Care Program. All contracts between the health plan and providers shall ensure that the provider complies with the consumer provisions outlined in the marketing guidelines.

v. 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.

w. Provisions requiring the subcontractor to comply with a;; fraud, waste, and abuse provisions contained herein that are applicable to providers or other subcontractors.

x. Provisions requiring the subcontractor to screen its employees to determine whether any of them have been excluded from participation in Medicare, Medicaid, CHIP, or any federal health care programs (as defined in Section 1128B(f) of the Act); have failed to renew license or certification registration; have revoked professional license or certification; or have 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 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 other such databases as the state agency may specify. The subcontract agreement shall require the health plan to promptly report relevant information disclosed as a result 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.

y. Provisions requiring that subcontractors that are providers or benefits 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 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 disclosure to be provided:
   - At the stage of credentialing and re-credentialing;
   - Upon execution of the provider agreement;
   - Within 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.

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 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;
  - ✓ Within 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.

z. Provisions requiring that subcontracted providers observe the following requirement:

1) The health plan shall submit the NPI on all encounter claim provider fields corresponding to those fields on a claim form where a provider NPI is required to be reported. The health plan shall submit the NPI with the corresponding unique health plan assigned provider identifier in the provider demographics file;

2) Implement a policy of, before providing a Medicaid service to a Managed Care Program adult member, requesting and inspecting the member's Managed Care Program identification card (or other documentation provided by the state agency demonstrating Managed Care Program 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 Managed Care Program member.

aa. Provisions specifying that no services under the subcontract may be performed outside the United States.

bb. 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.

4.12 Assignment:

4.12.1 The health plan shall understand and agree that in the event the Division of Purchasing 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 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.

4.13 Participation by Other Organizations:

4.13.1 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.

a. The health plan shall prepare and submit to the Division of Purchasing, 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.

b. The Division of Purchasing 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 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 determines that the health plan becomes compliant with the commitment, any funds retained as stated above, will be released.

c. 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.

1) The health plan must obtain the written approval of the Division of Purchasing for any new entities. This approval shall not be arbitrarily withheld.

2) If the health plan cannot obtain a replacement entity, the health plan must submit documentation to the Division of Purchasing detailing all efforts made to secure a replacement. The Division of Purchasing 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.

d. By 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. 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's website or another affidavit providing the same information.

4.14 Substitution of Personnel:

4.14.1 The health plan shall understand and agree 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 that no substitution of such specific key individual(s) and/or personnel qualifications shall be made without the prior written approval of the state agency. The health plan further agrees that any substitution made pursuant to this paragraph must be equal or better than originally proposed and that the state agency's approval of a substitution shall not be construed as an acceptance of the substitution's performance potential. The State of Missouri agrees that an approval of a substitution will not be unreasonably withheld.

4.15 Authorized Personnel:

4.15.1 The health plan shall only employ personnel authorized to work in the United States in accordance with applicable federal and state laws. This includes, at a minimum, the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) and INA Section 274A.

4.15.2 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 25% of the total amount due to the health plan.

4.15.3 The health plan shall agree to fully cooperate with any audit or investigation from federal, state, or local law enforcement agencies.

4.15.4 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, 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, a completed, notarized Affidavit of Work Authorization provided in the exhibit titled Business Entity Certification, Enrollment Documentation, and Affidavit of Work Authorization.

4.15.5 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.

4.16 Anti-Discrimination Against Israel Act Contractor Requirements:

4.16.1 If the health plan meets the definition of a company as defined in Section 34.600, RSMo, and has ten or more employees, the health plan shall not engage in a boycott of goods or services from the State of Israel; from companies doing business in or with Israel or authorized by, licensed by, or organized under the laws of the State of Israel; or from persons or entities doing business in the State of Israel as defined in Section 34.600, RSMo.

4.16.2 If the health plan meets the definition of a company as defined in Section 34.600, RSMo, and the company's employees increases to ten or more during the life of the contract, then the health plan shall submit to the Division of Purchasing a completed Box C of the exhibit titled, Anti-Discrimination Against Israel Act Certification, and shall comply with the requirements of Box C.

4.16.3 If during the life of the contract, the health plan's business status changes to become a company as defined in Section 34.600, RSMo, and the company has ten or more employees, then the health plan shall comply with, complete, and submit to the Division of Purchasing a completed Box C of the exhibit titled, Anti-Discrimination Against Israel Act Certification.

4.17 Health Plan Status:

4.17.1 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.

4.18 Coordination:

4.18.1 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 throughout the effective period of the contract.

4.19 Property of State:

4.19.1 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.

4.20 Confidentiality:

4.20.1 The health plan shall understand and agree 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 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.

4.20.2 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.

4.20.3 The health plan shall provide safe guards that restrict the use or disclosure of information concerning members to purposes directly connected with the administration of the contract.

4.20.4 The health plan shall not disclose the contents of member information or records to anyone other than the state agency, the member's legal guardian, or other parties with the member's written consent.

4.20.5 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 substance use disorder member records.

4.21 Performance Security Deposit:

4.21.1 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 within 30 calendar days after award of the contract and prior to performance of service under the contract.

a. The performance security deposit must be made payable to the State of Missouri in the amount of $3,000,000.00.

b. The contract number and contract period must be specified on the performance security deposit.

c. In the event the Division of Purchasing 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.

4.22 Force Majeure:

4.22.1 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, at a minimum, 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.

4.23 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:

4.23.1 Applicable Laws and Regulations - 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 – CFR 200.0-200.345.
b. Cost Principles - Cost Principles – 2 CFR 200.400-475 (Subpart E).

4.23.2 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.

4.23.3 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.

4.23.4 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.

4.23.5 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.

4.23.6 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.

4.23.7 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.).

4.23.8 If the health plan is a sub-recipient as defined in OMB Circular A-133, Section 210, the contractor 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.

4.23.9 The health plan shall comply with the public policy requirements as specified in the Department of Health and Human Services (HHS) Grants Policy Statement:
(https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf)

4.23.10 The health plan shall comply with Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104), as amended.

4.23.11 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 business days after the conviction.

4.23.12 Contractor 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.

4.23.13 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:

a. 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;
b. Equal Pay Act of 1963 (P.L. 88 -38, as amended, 29 U.S.C. Section 206 (d));
c. 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;
d. 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;
e. The Age Discrimination Act of 1975, as amended (42 U.S.C. 6101-6107) which prohibits discrimination on the basis of age;

f. Equal Employment Opportunity – E.O. 11246, “Equal Employment Opportunity”, as amended by E.O. 11375, “Amending Executive Order 11246 Relating to Equal Employment Opportunity”;
g. Missouri State Regulation, 19 CSR 10-2.010, Civil Rights Requirements;
h. Missouri Governor’s E.O. #94-03 (excluding article II due to its repeal);
i. Missouri Governor’s E.O. #05-30; and
j. The requirements of any other nondiscrimination federal and state statutes, regulations and executive orders which may apply to the services provided via the contract.

5. PROPOSAL SUBMISSION INFORMATION AND REQUIREMENTS

This section of the RFP includes information and instructions to the vendor that are integral to vendors offering a proposal. The contents of this section are informational and instructional. Many of the instructional provisions require certain actions by the vendor in offering a proposal.

5.1 Introduction:

5.1.1 The vendor's proposal should include a complete plan for accomplishing the tasks described in this RFP and any supplemental tasks the vendor has identified as necessary to successfully complete the obligations outlined in this RFP. The vendor's plan should demonstrate an understanding of and the ability to meet and perform all contractual requirements listed in this request, including all contractual services.

5.1.2 This section describes the contents and format designed to ensure completeness in the vendor's proposal. The intent of the instructions contained herein is to standardize the proposals to enable equitable measurements for competitive review for awarding to the lowest and best responsive vendor with a proposal that is the most advantageous to the state.

5.1.3 A proposal submitted by a vendor for a Specialty Plan will only be evaluated if the vendor's General Plan proposal is one of the three highest scoring proposals, and such vendor will be awarded a General Plan contract. Proposals submitted by vendors not selected for award as a General Plan contractor will not be evaluated in consideration for the Specialty Plan. The evaluation committee will evaluate each applicable vendor's Specialty Plan proposal in accordance with the evaluation criteria specified herein and within Attachment 5 – Technical Proposal Evaluation – Specialty Plan.

5.1.4 The vendor that has been selected as a General Plan contractor and that receives the highest Specialty Plan proposal score will be selected as the Specialty Plan contractor. Only one Specialty Plan contract will be awarded.

5.2 Submission of Solicitation Response:

5.2.1 MissouriBUYS is the State of Missouri's web-based statewide eProcurement system which is powered by WebProcure, through our partner, Proactis (https://www.missouribuys.mo.gov). Vendors must submit their solicitation response as an electronic response. The electronic method of submission is explained briefly below and in more detail in the step-by-step instructions provided at https://missouribuys.mo.gov/sites/missouribuys/files/how-to-respond-to-a-solicitation.pdf. (This document is also on the Bid Board referenced above.) Be sure to include the solicitation/opportunity (OPP) number, company name, and a contact name on any attachments.

a. In order to become a registered vendor, the vendor may register by going to the MissouriBUYS Home Page referenced above, clicking the "Register" button at the top of the page, and completing the Vendor Registration.

b. The vendor is solely responsible for ensuring timely submission of their solicitation response. Failure to allow adequate time prior to the solicitation end date to complete and submit a response to a solicitation, particularly in the event technical support assistance is required, places the vendor and their response at risk of not being accepted on time.

NOTE: The vendor shall understand and agree that regardless of any other reference herein which implies acceptance of other than electronic proposals, until otherwise notified by a subsequent addenda, only electronic proposals through MissouriBUYS may be accepted at this time.

5.2.2 Electronic Response in MissouriBUYS - Vendors must submit their entire response electronically through the MissouriBUYS System website. In addition to completing the on-line pricing, the registered vendor should submit completed exhibits, forms, and other information concerning the solicitation as an attachment to the

electronic response. The registered vendor is instructed to review the solicitation submission provisions carefully to ensure they are responding to all required pricing.

a. The exhibits, forms, and Pricing Pages provided herein may be saved, completed by a registered vendor, and then sent as an attachment to the electronic submission. Other information requested or required may be sent as an attachment. Additional instructions for submitting electronic attachments are on the MissouriBUYS System website.

1) To ensure software compatibility with the MissouriBUYS system, the vendor should complete attachments using Microsoft Word or Microsoft Excel, or if using a different application for completing attachments, the vendor should save the completed attachment as a searchable PDF document in order to preserve the formatting. A vendor's failure to follow these instructions and instead use a different application or method for completion and submission of attachments could render some of the vendor's response in their attachments to be unreadable which could negatively impact the evaluation of the vendor's response.

5.2.3 Compliance with Requirements, Terms and Conditions - Vendors are cautioned that the State of Missouri shall not award a non-compliant proposal. Consequently, any vendor indicating non-compliance or providing a response in conflict with mandatory requirements, terms, conditions or provisions of the RFP shall be eliminated from further consideration for award unless the state exercises its sole option to competitively negotiate the respective proposal(s) and the vendor resolves the noncompliant issue(s).

a. The vendor is cautioned when submitting pre-printed terms and conditions or other type material to make sure such documents do not contain terms and conditions which conflict with those of the RFP and its contractual requirements.

b. In order to ensure compliance with the RFP, the vendor should indicate agreement that, in the event of conflict between any of the vendor's response and the RFP requirements, terms and conditions, the RFP shall govern. Taking exception to the state's terms and conditions may render an vendor's proposal unacceptable and remove it from consideration for award.

5.3 Confidential Materials:

5.3.1 Pursuant to Section 610.021, RSMo, the vendor's proposal and related documents shall not be available for public review until a contract has been awarded or all proposals are rejected.

a. The Division of Purchasing is a governmental body under Missouri Sunshine Law (Chapter 610, RSMo). Section 610.011, RSMo, requires that all provisions be "*liberally construed and their exceptions strictly construed*" to promote the public policy that records are open unless otherwise provided by law.

b. Regardless of any claim by a vendor as to material being confidential and not subject to copying or distribution, or how a vendor characterizes any information provided in its proposal, all material submitted by the vendor in conjunction with the RFP is subject to release after the award of a contract in relation to a request for public records under the Missouri Sunshine Law (see Chapter 610, RSMo). Only information expressly permitted to be closed pursuant to the strictly construed provisions of Missouri's Sunshine Law will be treated as a closed record by the Division of Purchasing and withheld from any public request submitted to Division of Purchasing after award. The vendor should presume information provided to Division of Purchasing in a proposal will be public following the award of the contract or after rejection of all proposals and made available upon request in accordance with the provisions of state law. The vendor's sole remedy for the state's denial of any confidentiality request shall be limited to withdrawal of their proposal in its entirety. It is not the State of Missouri's intention to request any confidential material as part of the vendor's proposal. Therefore, vendors should NOT include confidential material with their proposal.

c. In no event will the following be considered confidential or exempt from the Missouri Sunshine Law:

1) Vendor's entire proposal including client lists, references, proposed personnel, and methodology including schedule of events and/or deliverables;

2) Vendor's pricing; and

3) Vendor's product specifications unless specifications specifically disclose scientific and technological innovations in which the owner has a proprietary interest (see subsection 15 of Section 610.021, RSMo).

d. On-line Proposal - If a registered vendor is responding electronically through the MissouriBUYS System website and attaches information with their proposal that is allowed by the Missouri Sunshine Law to be exempt from public disclosure, such specific material of their proposal must be attached as a separate document and must have the box "Confidential" selected when attaching the document. If the "Confidential" box is not selected when attaching the document, the document must be clearly marked as confidential along with an explanation of what qualifies the specific material to be held as confidential pursuant to the provisions of Section 610.021, RSMo. The vendor's failure to follow these instructions shall relieve the state of any obligation to preserve the confidentiality of the documents.

e. Imaging Ready - Except for any portion of a proposal qualifying as confidential as determined by the Division of Purchasing as specified above, after a contract is executed or all proposals are rejected, all proposals are uploaded into the Division of Purchasing's imaging system.

Addendum 03 revised the subparagraph below.

1) The uploaded information will be ***publicly*** accessible through the online Division of Purchasing Awarded Bid and Contract Document Search system. Therefore, the vendor is advised not to include any information in the proposal that the vendor does not want to be viewed by the public, including personal identifying information such as social security numbers.

2) In preparing a proposal, the vendor should be mindful of document preparation efforts for imaging purposes and storage capacity that will be required to image the proposal and should limit proposal content to items that provide substance, quality of content, and clarity of information.

5.4 Proposal Format:

5.4.1 To facilitate the evaluation process, the vendor is encouraged to organize their proposal into the following sections that correspond with the individual evaluation categories described herein. The vendor is cautioned that it is the vendor'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 vendor's failure to submit such information may cause an adverse impact on the evaluation of the proposal. The proposal should be page numbered and should have an index and/or table of contents referencing the appropriate page numbers.

a. Signed cover from the original RFP and all signed addendums should be placed at the beginning of the proposal.

b. Cost Proposal (Exhibit A - Pricing Pages Instructions & Information and Attachment 3 – Pricing Pages).

c. **Technical Proposal for the General Plan** - The Technical Proposal for the General Plan will include five components: Organizational Experience – General Plan (Exhibit B), Proposed Methodology and Approach – General Plan (Exhibit C), Quality – General Plan (Exhibit D), Access to Care and Care Management – General Plan (Exhibit E), and Medicaid Reform and Transformation – General Plan (Exhibit F). ***The Technical Proposal for the General Plan should be limited to no more than 450 pages, including any exhibits related to the Technical Proposal. Standard fonts, 11 point or above, should be used.***

1) The Technical Proposal for the General Plan should contain only relevant information that is specific to the General Plan. The vendor should provide a complete response to each question in the exhibits regarding the General Plan, independent from other information in the vendor's proposal.

2) ***The vendor's response should be straightforward and should not include assumptions, exceptions, or inferences.*** The use of technical language should be minimized and used only to describe a technical process. The evaluation committee will make no inferences or assumptions when evaluating vendor responses that are not clear, explicit, or thoroughly presented. The evaluation committee will not give weight to the vendor's use of contingent or non-binding language such as "exploring" or "taking under consideration" during the evaluation process.

3) The vendor should not include hyperlinks or video clips. In the event hyperlinks or video clips are provided, such information will not be considered.

d. **Technical Proposal for the Specialty Plan** – The Technical Proposal for the Specialty Plan will include seven components: Executive Summary – Specialty Plan (Exhibit G), Organizational Experience – Specialty Plan (Exhibit H), Methodology and Approach – Specialty Plan (Exhibit I), Quality – Specialty Plan (Exhibit J), Access to Care – Specialty Plan (Exhibit K), Care Management – Specialty Plan (Exhibit L), and Medicaid Reform and Transformation – Specialty Plan (Exhibit M). ***The Technical Proposal for the Specialty Plan should be limited to no more than 175 pages, including any exhibits related to the Technical Proposal. Standard fonts, 11 point or above, should be used.***

1) The Technical Proposal for the Specialty Plan should contain only relevant information that is specific to the Specialty Plan. The vendor should provide a complete response to each question in the exhibits regarding the Specialty Plan, independent from other information in the vendor's proposal.

2) ***The vendor's response should be straightforward and should not include assumptions, exceptions, or inferences.*** The use of technical language should be minimized and used only to describe a technical process. The evaluation committee will make no inferences or assumptions when evaluating vendor responses that are not clear, explicit, or thoroughly presented. The evaluation committee will not give weight to the vendor's use of contingent or non-binding language such as "exploring" or "taking under consideration" during the evaluation process.

3) The vendor should not include hyperlinks or video clips. In the event hyperlinks or video clips are provided, such information will not be considered.

e. Miscellaneous Exhibits/Information:
1) Minority Business Enterprise (MBE)/Women Business Enterprise (WBE) Participation, Organizations for the Blind and Sheltered Workshop Preference, and/or Missouri Service-Disabled Veteran Business Enterprise Participation
   - Exhibit N-Participation Commitment
   - Exhibit O-Documentation of Intent to Participate
2) Additional Miscellaneous Information:
   - Exhibit P- Business Entity Certification, Enrollment Documentation, and Affidavit of Work Authorization and Documentation (E-Verify)
   - Exhibit Q- Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transaction (Federal Debarment)
   - Exhibit R – Anti Discrimination Against Israel Act Certification
   - Exhibit S-Miscellaneous Information

5.5 Competitive Negotiation of Proposals:

5.5.1 The vendor is advised that under the provisions of this Request for Proposal, the Division of Purchasing 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:

5.5.2 Negotiations may be conducted in person, in writing, or by telephone.

5.5.3 Negotiations will only be conducted with potentially acceptable proposals. The Division of Purchasing reserves the right to limit negotiations to those proposals which received the highest rankings during the initial evaluation phase. All vendors involved in the negotiation process will be invited to submit a best and final offer.

5.5.4 Terms, conditions, prices, methodology, or other features of the vendor's proposal may be subject to negotiation and subsequent revision. As part of the negotiations, the vendor 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.

5.5.5 The mandatory requirements of the Request for Proposal shall not be negotiable and shall remain unchanged unless the Division of Purchasing determines that a change in such requirements is in the best interest of the State of Missouri.

5.6 Evaluation and Award Process – General Plan:

5.6.1 After determining that a proposal satisfies the mandatory requirements stated in the Request for Proposal, the evaluators shall use both objective analysis and subjective judgment in conducting an assessment of the proposals in accordance with the evaluation criteria stated below and the scoring details delineated in Attachment 4 for the General Plan. The contracts shall be awarded to the lowest and best proposals.

Evaluation Criteria for the General Plan		
Category	**Evaluation Element**	**Points**
TECHNICAL PROPOSAL		**190 points**
Organizational Experience		*10 points*
Methodology and Approach		*10 points*
Quality		*60 points*
	• HEDIS Measures • Health Outcomes Improvement Strategies and/EQRO Reports • Quality Assessment and Improvement Programs	20 points 20 points 20 points
Access to Care and Care Management (CM)		*75 points*
	• Primary Care • Specialty Care • Dental Services • Behavioral Health • Care Management (CM)	20 points 15 points 15 points 15 points 10 points
Medicaid Reform and Transformation		*35 points*
	• Personal Responsibility • State Provider Incentive Program • Accountability and Transparency • Local Community Care Coordination Program (LCCCP) • Value-Based Purchasing	5 points 5 points 2 points 8 points 15 points
MBE/WBE Participation		*10 points*
TOTAL		**200 points**

5.6.2 Details on the rating and scoring of the Technical Proposal for the General Plan may be found on Attachment 4.

5.6.3 The vendor is advised that an evaluation committee and other subject-matter experts will be used to review and assess the General Plan proposals for responsiveness to mandatory requirements of the RFP and in accordance with the subjective evaluation criteria stated in the RFP. The ethical standards of 1 Code of State Regulation (CSR) 40-1.050(7)(O) will apply to evaluators. Vendors may be sanctioned for unauthorized contact with any evaluator under 1 CSR 40-1.060(8)(G) and (H) available at http://www.sos.mo.gov/adrules/csr/csr.asp.

5.6.4 After an initial screening process, a question and answer conference or interview may be conducted with the vendor regarding their General Plan response, if deemed necessary by the Division of Purchasing. In addition, the vendor may be asked to make an oral presentation of their General Plan proposal during the conference. Attendance cost at the conference shall be at the vendor's expense. Such conference shall be coordinated by the Division of Purchasing.

5.6.5 A separate evaluation shall be conducted for the General Plan. The State of Missouri shall award no more than three General Plan Managed Care Program contracts for the combined Managed Care Program coverage area (Central, Eastern, Southwestern, and Western regions).

5.7 Evaluation of Organizational Experience – General Plan:

5.7.1 The Technical Proposal for the vendor's organizational experience will be considered subjectively in the evaluation process. The organizational experience for any vendor health care service subcontractor will also be considered subjectively in the evaluation process. Therefore, the vendor should submit the information requested on Exhibit B to document the vendor and any proposed health care service subcontractors' experiences in past/current performances, especially those performances related to the General Plan requirements of this RFP. The vendor should utilize Exhibit B, or a manner similar to the format provided on Exhibit B, to provide the requested information. Minimally, the vendor should ensure documentation of experience related to behavioral health services, vision, and dental subcontractors. As applicable, the vendor's response should include the vendor's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business. The vendor should address any current/previous managed care experiences operating in the State of Missouri.

5.7.2 For any contract experience detailed, the vendor should also provide reference contact information for a reference that can attest to the vendors', subcontractors', and benefit management organization's qualifications for fulfilling the requirements herein.

5.7.3 The vendor's organizational experience will be rated using the adjectival system as defined in Table 2 of Attachment 4. Details on the scoring of the vendor's organizational experience may be found on Table 3 of Attachment 4.

5.8 Evaluation of Proposed Methodology and Approach – General Plan:

5.8.1 The Technical Proposal for the vendor's proposed methodology and approach for the General Plan should demonstrate the method or manner in which the vendor proposes to satisfy the requirements of the RFP using the format on Exhibit C.

5.8.2 The language of the vendor's response to Exhibit C should be straightforward and limited to facts, solutions to problems, and plans of action to document the vendor has the infrastructure, systems, and procedures to deliver services and monitor member care.

5.8.3 The vendor's methodology and approach for the General Plan will be rated using the adjectival system as defined in Table 4 of Attachment 4. Details on the scoring of the vendor's methodology and approach may be found on Table 5 of Attachment 4.

5.9 Evaluation of Quality – General Plan:

5.9.1 The Technical Proposal for the vendor's quality should provide information on the vendor's ability to provide quality care and improve patient outcomes, as documented in current and in proposed programs using Exhibit D to explain how the vendor will satisfy the requirements of the RFP.

5.9.2 The vendor's General Plan quality will be rated using the adjectival system as defined in Table 6 of Attachment 4. Details on the scoring of the vendor's General Plan quality may be found on Table 7 of Attachment 4.

5.10 Evaluation of Access to Care and Care Management (CM) – General Plan:

5.10.1 The Technical Proposal for the vendor's access to Primary Care, Specialty Care, Dental Services, Behavioral Health Services, and CM will be considered subjectively in the evaluation process. Therefore, the vendor should respond to the questions on Exhibit E to provide the requested information. In addition to contracted providers, the vendor should address any subcapitated arrangements within the vendor's response.

5.10.2 The vendor should submit documentation demonstrating that the vendor's Primary Care, Specialty Care, Dental Services, Behavioral Health, and CM networks comply with travel distance standards as set forth by DCI in 20 CSR 400-7.095 regarding Provider Network Adequacy Standards.

5.10.3 The vendor should also submit documentation for those Primary Care, Specialty Care, Dental Services, Behavioral Health, and CM providers not addressed under 20 CSR 400-7.095, ensuring members will have access to Primary Care, Specialty Care, Dental Service, Behavioral Health, and CM providers within 30 miles of member domicile, unless the vendor can demonstrate that there is no licensed Primary Care, Specialty Care, Behavioral Health, or Dental Service provider in that area, in which case the vendor should ensure members have access to Primary Care, Specialty Care, Behavioral Health, and Dental Service providers within 60 miles of member domicile. For any demonstrated access that differs from these standards, the vendor should submit proof of approval of the differences by DCI and should describe how the vendor will ensure that members in the counties with access differences approved by DCI are guaranteed access to the necessary providers.

5.10.4 The vendor should provide documentation verifying that the vendor's Primary Care, Specialty Care, Behavioral Health, and Dental Service network has adequate capacity. Such documentation should include, at a minimum, appointment availability, 24 hours/seven days a week access, sufficient experienced Primary Care, Specialty Care, Behavioral Health, and Dental Service providers to serve special needs populations, waiting times, open panels, and PCP to member ratios.

5.10.5 The vendor should complete and submit the applicable portions of Attachment 6 – Federally Qualified Health Clinics, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Family Planning, and STD Providers, documenting each FQHC, IRHC, PBRHC, 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, and Family Planning and STD Providers, proposed to be included in the vendor's provider network.

5.10.6 The vendor's Access to Care and CM for the General Plan will be rated using the adjectival system as defined in Table 8 of Attachment 4. Details on the scoring of the vendor's access to care and CM for the General Plan may be found on Table 9 of Attachment 4.

5.11 Evaluation of Medicaid Reform and Transformation – General Plan:

5.11.1 The Technical Proposal for the vendor's Medicaid reform and transformation should provide detail regarding the vendor's proposed programs involving personal responsibility and promoting efficiency through state provider incentive programs, LCCCPs designed to engage members, providers, and health plans in transforming the state agency's service delivery system, and increasing accountability and transparency will be considered in the evaluation process. Therefore, the vendor should respond to the questions on Exhibit F to provide the requested information.

5.11.2 The Technical Proposal for the vendor's Medicaid Reform and Transformation should also provide detail regarding the vendor's proposed Value-Based Purchased Models and Purchasing Strategies. The state agency reserves the right to require the health plan to participate in a state-selected Value-Based Purchasing Model and/or Purchasing Strategy during any period of the contract. Examples of Value-Based Models and Purchasing Strategies are as follow:

a. Social Determinants of Health – The state agency seeks innovative health plan models and strategies to address Social Determinants of Health that impact the overall health and well-being of members and result in decreased medical expenditures. Such models and strategies may include direct interventions by the health plan and/or linkages to local resources or community based organizations for members that result in

employment opportunities, housing supports, food and nutritional security, educational opportunities, and advancement in education levels. Such interventions may be accomplished through the use of web-based technologies that link members to available resources, community health workers or similar providers that are health plan staff or embedded with participating providers, or other interventions that address Social Determinants of Health. The state agency is interested in innovative models and strategies that focus on members who are pregnant, managing chronic diseases, experiencing housing and food insecurities, or showing high emergency department (hereinafter referred to as ED) utilization.

b. Behavioral Health Services – The state seeks innovative provider contracting models and strategies to address behavioral health service needs including mental health and addiction services. The alternative payment models and strategies shall be designed to reduce total cost of care, address gaps and improve access to services, ensure quality of providers, provide incentives for "warm handoff" transitions from institutions to less-restrictive and less costly treatment programs in community-based programs and services, allow for seamless follow-up care, and divert service delivery from institutions where appropriate, particularly ED diversion resulting in reduced inpatient admissions. The state agency is interested in a service focus of the models and strategies including, at a minimum, effective care management with a particular focus on managing individuals' behavioral and physical health needs.

c. Physical and Behavioral Health Integration Strategies – The state agency seeks innovative models and strategies for integration of physical and behavioral health services. A 2015 Government Accountability Office report (GAO-15-460) showed that nationally, over half of the Medicaid-only members in the top 5% of expenditures had a mental health condition and one-fifth had a substance use disorder (hereinafter referred to as SUD). That report also observed that "Although individuals with mental health conditions have some of the greatest health care needs (including complex polypharmacy regimens); the health care system is often too fragmented to effectively and efficiently serve them." The state agency is particularly interested in models and strategies that specify how to better identify, treat, and transition members to appropriate behavioral health services and providers when presenting at the hospital with an emergent medical condition.

d. Telemedicine Projects – The state agency seeks innovative health plan developed models and strategies to expand the use and effectiveness of telemedicine, including telemonitoring and telementoring programs. Such models and strategies should focus on strategies to enhance access to services for rural areas, access to behavioral health services, and support of chronic pain management interventions. The state agency is interested in models and strategies that leverage Show-Me ECHO. The state agency currently reimburses for any telemedicine service provided with the same standard of care as an in-person service. The state agency reimburses originating site (where the patient is located) fees and distant site (where the provider is located) fees. The state agency plans to file a new telemedicine regulation in 2021. The state agency is also interested in models and strategies to address telemedicine strategies employed during the COVID-19 pandemic that may be extended or enhanced beyond the Public Health Emergency.

    1) Other Telemedicine Projects – The vendor should understand and agree that as telemedicine capabilities increase, the health plan may have access to additional models and strategies not identified above.

5.11.3 The vendor's Medicaid Reform and Transformation for the General Plan will be rated using the adjectival system as defined in Table 10 of Attachment 4. Details on the scoring of the vendor's Medicaid reform and transformation for the General Plan may be found on Table 11 of Attachment 4.

5.12 Evaluation and Award Process – Specialty Plan:

5.12.1 After determining that a proposal satisfies the mandatory requirements stated in the Request for Proposal, the evaluators shall use both objective analysis and subjective judgment in conducting an assessment of the proposals in accordance with the evaluation criteria stated below and the scoring details delineated in Attachment 5 for the Specialty Plan. The contract shall be awarded to the lowest and best proposal.

Evaluation Criteria for the Specialty Plan		
Category	**Evaluation Element**	**Points**
TECHNICAL PROPOSAL		**190 points**
Organizational Experience		*15 points*
	• Overall Experience, Experience Relevant to Required Services, References, Contract Terminations/Non-Renewals, Contract Breaches • Innovative Experience	10 points 5 points
Methodology and Approach		*15 points*
	• Program Administration - Specialty Plan Monitoring, Program and Provider Monitoring, and Prescriber Oversight • Provider Services – Communication Strategies, Eligibility and Enrollment Issue Resolution • Member Services – Communication Strategies, Eligibility and Enrollment Issue Resolution	5 points 5 points 5 points
Quality		*40 points*
	• Non-HEDIS Metrics • Specialty Plan Quality Program • Clinical Practice Guidelines • Member, Family, and Stakeholder Advisory Council	5 points 25 points 5 points 5 points
Access to Care		*50 points*
	• Network Development and Management – Network Adequacy Standards; Community-Based, Integrated, Trauma-Informed Services; Access to Specialty Providers; Network Gaps and Strategies; and Additional Health Benefits • Timely Access to Specialty Services and Trauma-Informed Care, Inpatient Hospital Boarding, Non-Emergency Medical Transportation (NEMT), In-Lieu of Services or Settings (ILOS), and Additional Health Benefits.	25 points 25 points
Care Management (CM)		*60 points*
	• Specialty Plan Care Management (CM) Program • Coordination with Other Entities • Consent • Use Cases	40 points 5 points 5 points 10 points
Medicaid Reform and Transformation		*10 points*
	• Provider Incentive Programs • Value-Based Purchasing Preparatory Activities	5 points 5 points
MBE/WBE Participation		**10 Points**
TOTAL		**200 points**

5.12.2 Details on the rating and scoring of the Technical Proposal for the Specialty Plan may be found on Attachment 5.

5.12.3 The vendor is advised that an evaluation committee and other subject-matter experts will be used to review and assess the Specialty Plan proposals for responsiveness to mandatory requirements of the RFP and in accordance with the subjective evaluation criteria stated in the RFP. The ethical standards of 1 Code of State Regulation (CSR) 40-1.050(7)(O) will apply to evaluators. Vendors may be sanctioned for unauthorized contact with any evaluator under 1 CSR 40-1.060(8)(G) and (H) available at http://www.sos.mo.gov/adrules/csr/csr.asp.

5.12.4 After an initial screening process, a question and answer conference or interview may be conducted with the vendor regarding their Specialty Plan response, if deemed necessary by the Division of Purchasing. In addition, the vendor may be asked to make an oral presentation of their Specialty Plan proposal during the conference.

Attendance cost at the conference shall be at the vendor's expense. Such conference shall be coordinated by the Division of Purchasing.

5.12.5 A separate evaluation shall be conducted for the Specialty Plan, consisting of any vendors proposing Specialty Plan services that were awarded a General Plan contract. The one Specialty Plan Managed Care Program contract will be awarded for the combined Managed Care Program coverage area (Central, Eastern, Southwestern, and Western regions).

5.13 Evaluation of Executive Summary – Specialty Plan:

5.13.1 The Technical Proposal for the vendor should include an executive summary as part of their Specialty Plan proposal. The vendor should use Exhibit G to provide the information requested. However, the vendor should understand and agree that the information provided as part of the executive summary will not be evaluated or scored, but may be reviewed by the evaluators and may be used in part or in whole in public communications following contract award.

5.14 Evaluation of Organizational Experience – Specialty Plan:

5.14.1 The Technical Proposal for the vendor's organizational experience will be considered subjectively in the evaluation process. The organizational experience for any vendor health care service subcontractor will also be considered subjectively in the evaluation process. Therefore, the vendor should submit the information requested on Exhibit H to document the vendor and any proposed health care service subcontractors' experiences in past/current performance, especially those performances related to the Specialty Plan requirements of this RFP. The vendor should utilize Exhibit H, or a manner similar to the format provided on Exhibit H, to provide the requested information. The vendor's response should include the vendor's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business. The vendor should discuss any current/previous managed care experiences operating in Missouri.

5.14.2 For any contract experience detailed, the vendor should also provide reference contact information for a reference that can attest to the vendors', subcontractors' and benefit management organization's qualifications for fulfilling the requirements herein.

5.14.3 The vendor's organizational experience for the Specialty Plan will be rated using the adjectival system as defined in Table 2 of Attachment 5. Details on the scoring of the vendor's organizational experience for the Specialty Plan may be found on Table 3 of Attachment 5.

5.15 Evaluation of Proposed Methodology and Approach – Specialty Plan:

5.15.1 The Technical Proposal for the vendor's proposed methodology and approach for the Specialty Plan should demonstrate the method or manner in which the vendor proposes to satisfy the requirements of the RFP using the format on Exhibit I.

5.15.2 The language of the vendor's response to Exhibit I should be straightforward and limited to facts, solutions to problems, and plans of action to document the vendor has the infrastructure, systems, and procedures to deliver services and monitor member care.

5.15.3 The vendor's methodology and approach for the Specialty Plan will be rated using the adjectival system as defined in Table 4 of Attachment 5. Details on the scoring of the vendor's methodology and approach for the Specialty Plan may be found on Table 5 of Attachment 5.

5.16 Quality – Specialty Plan:

5.16.1 The Technical Proposal for the vendor's quality should provide information on the vendor's ability to provide quality care and improve patient outcomes, as documented in current programs and in proposed programs using Exhibit J to explain how the vendor will satisfy the requirements of the RFP.

5.16.2 The vendor's Specialty Plan quality will be rated using the adjectival system as defined in Table 6 of Attachment 5. Details on the scoring of the vendor's Specialty Plan quality scoring may be found on Table 7 of Attachment 5.

5.17 Evaluation of Access to Care – Specialty Plan:

5.17.1 The Technical Proposal for the Specialty Plan's member access to Behavioral Health Services will be considered subjectively in the evaluation process. Therefore, the vendor should respond to the questions on Exhibit K to provide the requested information. In addition to the contracted providers, the vendor should address any subcapitated arrangements within the vendor's response.

5.17.2 The vendor should complete and submit all applicable portions of Attachment 6 – Federally Qualified Health Clinics, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Family Planning, and STD Providers, documenting each FQHC, IRHC, PBRHC, CMHC, Safety Net Hospitals (including acute care safety net hospitals as defined in 13 CSR 70-15.010 of the CSR, as amended), LPHA, and Family Planning and STD Providers, proposed to be included in the vendor's provider network.

5.17.3 The vendor's access to care for the Specialty Plan will be rated using the adjectival system as defined in Table 8 of Attachment 5. Details on the scoring of the vendor's access to care for the Specialty Plan may be found on Table 9 of Attachment 5.

5.18 Evaluation of Care Management (CM):

5.18.1 The Technical proposal for the vendor's ability to meet Specialty Plan CM requirements will be considered subjectively in the evaluation process. Therefore, the vendor should respond to the questions on Exhibit L to provide the requested information.

5.18.2 The vendor's CM for the Specialty Plan will be rated using the adjectival system as defined in Table 10 of Attachment 5. Details on the scoring of the vendor's CM for the Specialty Plan may be found on Table 11 of Attachment 5.

5.19 Evaluation of Medicaid Reform and Transformation:

5.19.1 The Technical Proposal for the vendor's ability to meet Specialty Plan Medicaid reform and transformation requirements will be considered subjectively in the evaluation process. Therefore, the vendor should respond to the questions on Exhibit M to provide the requested information.

5.19.2 The vendor's Medicaid reform and transformation for the Specialty Plan will be rated using the adjectival system as defined in Table 12 of Attachment 5. Details on the scoring of the vendor's Medicaid reform and transformation for the Specialty Plan may be found on Table 13 of Attachment 5.

5.20 Evaluation of Vendor's Minority Business Enterprise (MBE)/ Women Business Enterprise (WBE) Participation:

5.20.1 In order for the Division of Purchasing (Purchasing) to meet the provisions of Executive Order 05-30, the vendor 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 may be met by a qualified MBE/WBE vendor 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 vendor'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.)

5.20.2 The vendor'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. If Participation Meets Target: Vendors 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. If Participation Exceeds Target: Vendors 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. If Participation Below Target: Vendors 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. If No Participation: Vendors failing to propose any commercially useful MBE/WBE participation shall be assigned a score of zero in this evaluation category.

5.20.3 MBE/WBE Participation evaluation points shall be assigned using the following formula:

$$\frac{\text{Vendor's Proposed MBE \% } \leq 10\% + \text{WBE \% } \leq 5\%}{\text{State's Target MBE \% (10) + WBE \% (5)}} \times \text{Maximum MBE/WBE Participation Evaluation points (10)} = \text{Assigned MBE/WBE Participation points}$$

5.20.4 If the vendor is proposing MBE/WBE participation, in order to receive evaluation consideration for MBE/WBE participation, the vendor must provide the following information with the proposal.

a. Participation Commitment - If the vendor is proposing MBE/WBE participation, the vendor must complete Exhibit N, 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 vendor submitting the proposal is a qualified MBE and/or WBE, the vendor must include the vendor in the appropriate table on the Participation Commitment Form.

b. Documentation of Intent to Participate – The vendor must either provide a properly completed Exhibit O, Documentation of Intent to Participate Form, recently signed by each MBE and WBE proposed or must provide a letter of intent recently signed 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 vendor submitting the proposal is a qualified MBE and/or WBE, the vendor is not required to complete Exhibit O, Documentation of Intent to Participate Form or provide a recently signed letter of intent.

5.20.5 Commitment – If the vendor's proposal is awarded, the percentage level of MBE/WBE participation committed to by the vendor on Exhibit N, Participation Commitment, shall be interpreted as a contractual requirement.

5.20.6 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, Native Alaskans, and other groups that may be recognized by the Office of Advocacy, United States Small Business Administration, Washington, D.C.

5.20.7 Resources - A listing of several resources that are available to assist vendors 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 870-B, 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

5.21 Miscellaneous Submittal Information:

5.21.1 Organizations for the Blind and Sheltered Workshop Preference - Pursuant to Section 34.165, RSMo, and 1 CSR 40-1.050, a five to fifteen (5-15) bonus point preference shall be granted to vendors 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 five to fifteen (5-15) bonus points, the following conditions must be met and the following evidence must be provided:

1) The vendor 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, at a minimum, 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 the 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 are utilized, to any extent, in the vendor'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 vendor 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 vendor must provide the requested information with the proposal.

4) A sliding scale for the award of points shall range from a minimum of five points to a maximum of 15 points. The award of the minimum five points shall be based on the proposal containing a commitment

that the participating nonprofit organization or workshop is providing the greater of 2% or $5,000 of the total contract value of proposals for purchases not exceeding ten million dollars.

b. Where the commitment in the proposal exceeds the minimum level set forth in Section 34.165, RSMo to obtain five points, the awarded points shall exceed the minimum five points, up to a maximum of 15 points. As the statute sets out a minimum of five points for a minimum 2% commitment, each percent of commitment is worth two and one-half (2.5) points. The formula to determine the awarded points for commitments above the 2% minimum shall be calculated based on the commitment in the proposal (which in the formula will be expressed as a number [Vendor's Commitment Number below], not as a percentage) times two and one-half (2.5) points:

Vendor's Commitment Number x 2.5 points = Awarded Points

Examples: A commitment of three percent (3%) would be calculated as: 3 x 2.5 points = 7.5 awarded points. A commitment of 5.5% would be calculated as: 5.5 x 2.5 points = 13.75 awarded points. If, instead of a percentage, a vendor's proposal lists a dollar figure that is over the minimum amount, the dollar figure shall be converted into the percentage of the vendor's total contract value for calculation of the awarded points. Commitments at or above 6% receive the maximum of 15 points.

1) Participation Commitment - The vendor must complete Exhibit N, Participation Commitment, by identifying the organization for the blind or sheltered workshop, the amount of participation committed, and the commercially useful products/services to be provided by the listed organization for the blind or sheltered workshop. If the vendor submitting the proposal is an organization for the blind or sheltered workshop, the vendor must be listed in the appropriate table on the Participation Commitment Form.

2) Documentation of Intent to Participate – The vendor must either provide a properly completed Exhibit O, Documentation of Intent to Participate Form, or letter of intent recently signed by the proposed 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 vendor submitting the proposal is an organization for the blind or sheltered workshop, the vendor is not required to complete Exhibit O, Documentation of Intent to Participate Form or provide a letter of intent.

c. A list of Missouri sheltered workshops may be found at the following Internet address:

Listing of Missouri Sheltered Workshops:
http://dese.mo.gov/special-education/sheltered-workshops/directories

Missouri Sheltered Workshop Products/Services Locator:
http://moworkshops.org/services.html

d. The websites for the Missouri Lighthouse for the Blind and the Alphapointe Association for the Blind may be found at the following Internet addresses:

http://www.lhbindustries.com
http://www.alphapointe.org

e. Commitment – If the vendor's proposal is awarded, the organization for the blind or sheltered workshop participation committed to by the vendor on Exhibit N, Participation Commitment, shall be interpreted as a contractual requirement.

5.21.2 Service-Disabled Veteran Business Enterprises (SDVEs) – Pursuant to Section 34.074, RSMo, and 1 CSR 40-1.050, the Division of Purchasing (Purchasing) has a goal of awarding 3% of all contracts for the performance

of any job or service to qualified service-disabled veteran business enterprises (SDVEs). A three point bonus preference shall be granted to vendors 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 vendor must either be an SDVE or must be proposing to utilize an SDVE as a subcontractor and/or supplier that provides at least 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 vendor'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 vendor must provide the following information with the proposal:

- Participation Commitment - The vendor must complete Exhibit N, 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 vendor submitting the proposal is a qualified SDVE, the vendor must be listed in the appropriate table on the Participation Commitment Form.

- Documentation of Intent to Participate – The vendor must either provide a properly completed Exhibit O, Documentation of Intent to Participate Form or letter of intent recently signed by the proposed 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 three years to the Purchasing, the vendor **must** provide the following Service-Disabled Veteran (SDV) documents:

  ✓ A copy of the SDV's Certificate of Release or Discharge from Active Duty (DD Form 214), and

  ✓ A copy of the SDV's disability rating letter issued by the Department of Veterans Affairs establishing a service connected disability rating, or a Department of Defense determination of service connected disability.

NOTE:

✓ If the vendor submitting the proposal is a qualified SDVE, the vendor must include the SDV Documents as evidence that the vendor qualifies as an SDVE. However, the vendor is not required to complete Exhibit O, Documentation of Intent to Participate Form or provide a recently dated letter of intent.

✓ If the SDVE and SDV are listed on the following internet address, the vendor is not required to provide the SDV Documents listed above.
http://oa.mo.gov/sites/default/files/sdvelisting.pdf

b. Commitment – If awarded a contract, the SDVE participation committed to by the vendor on Exhibit N, 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 51% of the business owned by one or more service-disabled veterans (SDVs) or, in the case of any publicly-owned business, not less than 51% of the stock of which is owned by one or more SDVs;

3) SDVE has the management and daily business operations controlled by one or more SDVs;

4) SDVE has a copy of the SDV's Certificate of Release or Discharge from Active Duty (DD Form 214), and a copy of the SDV's disability rating letter issued by the Department of Veterans Affairs establishing a service connected disability rating, or a Department of Defense determination of service connected disability; and

5) SDVE possesses the power to make day-to-day as well as major decisions on matters of management, policy, and operation.

5.21.3 Affidavit of Work Authorization and Documentation - Pursuant to Section 285.530, RSMo, if the vendor meets the Section 285.525, RSMo, definition of a "business entity" ((http://www.moga.mo.gov/mostatutes/stathtml/28500005301.html?&me=285.530), the vendor must affirm the vendor'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 vendor should complete applicable portions of Exhibit P, Business Entity Certification, Enrollment Documentation, and Affidavit of Work Authorization. The applicable portions of Exhibit P must be submitted prior to an award of a contract.

5.21.4 Debarment Certification – The vendor certifies by signing the signature page of this original document and any addendum signature page(s) that the vendor 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 vendor should complete and return the attached certification regarding debarment, etc., Exhibit Q with the proposal. This document must be satisfactorily completed prior to award of the contract.

5.21.5 Anti-Discrimination Against Israel Act Certification Exhibit Instructions - Regardless of company status or number of employees, vendor is requested to complete and submit the applicable portion of Exhibit R - Anti-Discrimination Against Israel Act Certification with their response. Pursuant to Section 34.600, RSMo, if the vendor meets the Section 34.600, RSMo, definition of a "company" (https://revisor.mo.gov/main/OneSection.aspx?section=34.600) and the vendor has ten or more employees, the vendor must certify in writing that the vendor is not currently engaged in a boycott of goods or services from the State of Israel as defined in Section 34.600, RSMo, and shall not engage in a boycott of goods or services from the State of Israel, if awarded a contract, for the duration of the contract. The applicable portion of the exhibit must be submitted prior to an award of a contract.

5.21.6 The vendor should complete and submit Exhibit S, Miscellaneous Information.

5.21.7 Business Compliance - The vendor must be in compliance with the laws regarding conducting business in the State of Missouri. The vendor certifies by signing the signature page of this original document and any addendum signature page(s) that the vendor 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 vendor shall provide documentation of compliance upon request by the Division of Purchasing. The compliance to conduct business in the state shall include, but not necessarily be limited to:

a. Registration of business name (if applicable) with the Secretary of State at http://sos.mo.gov/business/startBusiness.asp
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)

The vendor should refer to the Missouri Business Portal at http://business.mo.gov for additional information.

END OF PART FOUR: PROPOSAL SUBMISSION INFORMATION AND REQUIREMENTS

Addendum 02 revised Exhibit A.

EXHIBIT A

PRICING PAGES INSTRUCTIONS AND INFORMATION

1. The Pricing Pages are included as Attachment 3. The Pricing Pages 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 RFP. For the period represented on the Pricing Pages, the vendor shall indicate with an "x" in Column 2, the vendor's 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. The vendor's proposal shall cover the Central, Eastern, Southwestern, and Western regions. All costs associated with providing the required services are included in the firm, fixed rates.

2. The vendor must complete Column 2 on the Pricing Pages for the Western region, Eastern region, Central region, and the Southwestern region. The vendor must complete also complete Column 2 on the Pricing Pages related to the capitation payment rates under the scenario that the state agency implements Medicaid expansion for the Western region, Eastern region, Central region, and the Southwestern region.

3. Requirements promulgated by the federal government stipulate that the State of Missouri may 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.

Addendum 02 added language to the instructions below.

4. To assist the vendor in review of the firm, fixed rates, the vendor should use the information provided in Attachment 2 - Actuarial Memorandum. ***Additional information regarding rate calculations may be found on Attachment 7 – Actuarial Memorandum Appendices***. However, the vendor is advised that this information should not be used as the only source of information in making pricing decisions. The vendor is solely responsible for research, preparation, and documentation of the vendor's proposal including the acceptance of the rates quoted on the Pricing Pages.

Addendum 02 deleted language to the instructions below.

a. Any vendor 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.

Addendum 02 deleted the information below.

b. DELETED.

Addendum 02 added language to the instructions below.

c. ***In addition to completing the Pricing Pages as indicated above, t***he vendor 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). The certification shall include the methodology and assumptions used in evaluating the proposed rates for the vendor's particular circumstances and shall comport with Actuarial Standards of Practice (ASOPs), with specific consideration of ASOPs #41 and #49.

d. The vendor 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. The vendor shall understand and agree that the firm, fixed prices on the Pricing Pages reflect the following.

EXHIBIT A

PRICING PAGES INSTRUCTIONS AND INFORMATION

a. The cost of marketing as an administrative expense associated with the start-up fees and costs to support expansion into Missouri Medicaid regions.

   1) The actuarially sound firm, fixed rates provided are net of Third Party Liability recoveries.

   2) 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.

   3) The actuarially sound firm, fixed rates reflect the average risk of the region.

   4) The vendor 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 will not consider awarding a contract to a vendor with any quoted rate which deviates from the state's firm, fixed rate listed in Column 1.

b. The actuarially sound firm, fixed rates provided do not include:

   1) Estimates for services which are not the vendor's responsibility.

Addendum 03 and Addendum 02 revised Exhibit B.

EXHIBIT B

TECHNICAL PROPOSAL – GENERAL PLAN – ORGANIZATIONAL EXPERIENCE

Directions for Vendor - The vendor should provide the information requested from the vendor's Organizational Experience related to past/current performance, especially that related to the General Plan requirements of the RFP. The vendor's response should align with the requirements specified in Section 2, Scope of Work – General Plan, and Section 4 - Contractual Requirements. ******REMINDER – The combined Technical Proposal for the General Plan should be no longer than 450 pages.***

In presenting the vendor's Organizational Experience, the vendor should discuss the following areas:

Addendum 03 revised the question below.

1. ***Publicly*** Funded Managed Care Contracts - The vendor should identify all the vendor's and proposed health care service subcontractors' ***publicly***-funded Managed Care contracts for Medicaid, CHIP, and/or other low-income individuals within the past five years.

Vendor's ***Publicly***-Funded Managed Care Contracts	Number of Members	Populations Served (e.g. Medicaid, CHIP, and/or other low-income individuals)

Subcontractor's ***Publicly***-Funded Managed Care Contracts	Number of Members	Populations Served (e.g. Medicaid, CHIP, and/or other low-income individuals)

Addendum 03 revised the question below.

2. Managed Care Contracts for Populations Other than Medicaid, CHIP, and/or Other Low-Income Individuals - The vendor should identify the vendor's and proposed health care service subcontractors' five 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 years.

Vendor's ***Publicly***-Funded Managed Care Contracts	Number of Members	Populations Served Other Than Medicaid, CHIP, and/or other low-income individuals
1.		
2.		
3.		
4.		
5.		

EXHIBIT B, CONTINUED…

TECHNICAL PROPOSAL – GENERAL PLAN – ORGANIZATIONAL EXPERIENCE

Subcontractor's ***Publicly***-Funded Managed Care Contracts	Number of Members	Populations Served Other Than Medicaid, CHIP, and/or other low-income individuals
1.		
2.		
3.		
4.		
5		

Addendum 03 revised the question below.

3. Non-***Publicly*** Funded Managed Care Contracts for Populations Other Than Medicaid, CHIP, and/or Other Low-Income Individuals - If the vendor 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 years, the vendor should identify the vendor's and the proposed subcontractors' ten largest (as measured by number of members) Managed Care contracts for populations other than Medicaid, CHIP, and/or other than low-income individuals within the past five years.

Vendor's Non-***Publicly*** Funded Managed Care Contracts	Number of Members	Populations Served (e.g. Other than Medicaid, CHIP, and/or other low-income individuals)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10		

Subcontractor's Non-***Publicly*** Funded Managed Care Contracts	Number of Members	Populations Served (e.g. Other than Medicaid, CHIP, and/or other low-income individuals)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

EXHIBIT B, CONTINUED…

TECHNICAL PROPOSAL – GENERAL PLAN – ORGANIZATIONAL EXPERIENCE

Addendum 02 revised the instructions below.

4. The vendor should provide the following information for two separate contracts each ***(1 for vendor and 1 for subcontractor),*** as the vendor has identified in questions 1, 2, and 3 above (total of 6). ***If the vendor cannot provide information for any of the above-referenced questions, then the number of references may be reduced.*** The vendor should copy and complete this form documenting the vendor and subcontractor's current/prior experience considered most relevant to the services required herein.

Vendor Name or Subcontractor Name: _____
(if reference is for a Subcontractor):

Reference Information (Current/Prior Services Performed For:)					
Name, Title, Address, and Contact Information (telephone 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 Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract:	Year: Population: No. of Members:	Year: Population: No. of Members:	Year: Population: No. of Members:	Year: Population: No. of Members:	Year: Population: No. of Members:
Annual Contract Payment:	Year:	Year:	Year:	Year:	Year:
Description of services performed, including whether the vendor 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 B, CONTINUED…

TECHNICAL PROPOSAL – GENERAL PLAN – ORGANIZATIONAL EXPERIENCE

5. Contracts Terminated/Not-Renewed – The vendor should identify whether the vendor has had a contract terminated or nor renewed within the past five years. If so, the vendor should describe the reason(s) for the termination/non-renewal and the parties involved, and should provide the address and telephone number of the client. If the contract was terminated/not-renewed based upon the vendor's performance, the vendor should describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. The vendor's response should address the vendor's parent organization, affiliates, and subsidiaries conducting Medicaid or other state federal health business.

Vendor's Terminated/Non-Renewed Contracts:	Contracting Entity, including Address and Telephone Number:	Reason for Termination/Non-Renewal, including any Corrective Actions Taken to Prevent Future Occurrence of Problem

6. Contracts Breached – The vendor should identify whether a contracting party found the vendor to be in breach of any of the vendor's physical or behavioral health services contracts within the past five years. If so, the vendor should (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 vendor's control, (2) if a corrective action plan was imposed, the vendor should describe the steps and timeframes in the corrective action plan and whether the corrective action plan was completed, (3) if a sanction was imposed, the vendor should 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, the vendor should indicate the result of the proceeding/litigation. The vendor's response should address the vendor's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business. The vendor should copy and complete this form for each of the vendor's contract(s) found to be in breach of any of the vendor's physical or health services contracts within the past five years.

Contract Breached (Title, name of service/contract, client name):	
Description of events concerning the breach including whether the breach was due to factors beyond the vendor's control:	
Description of steps and timeframes of corrective action plan, if any, and whether the corrective action plan was completed:	
Description of any sanction, if any, including the amount of monetary sanction imposed:	
Description of result of breach, proceeding, or litigation, if any:	

EXHIBIT B, CONTINUED…

TECHNICAL PROPOSAL – GENERAL PLAN – ORGANIZATIONAL EXPERIENCE

7. Current Subcontract Relationships - The vendor should identify any contracts in which the proposed subcontractors are currently providing services for the vendor. The vendor should also 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

Addendum 02 revised Exhibit C.

EXHIBIT C

TECHNICAL PROPOSAL - PROPOSED METHODOLOGY AND APPROACH – GENERAL PLAN

Directions for Vendor – The vendor should provide the information requested from the vendor's Methodology and Approach, especially that related to the General Plan requirements of the RFP. The vendor's response should align with the requirements specified in Section 2, Scope of Work – General Plan, and Section 4 - Contractual Requirements.
******REMINDER – The combined Technical Proposal for the General Plan should be no longer than 450 pages.***

In presenting the Proposed Methodology and Approach, the vendor should discuss the following areas:

Program Administration

1. The vendor should describe their proposed process for monitoring service delivery, which should include, at a minimum, the vendor's process for evaluating the adequacy, sufficiency, and appropriateness of provided services and monitoring patient outcomes.

2. The vendor should describe their proposed process for monitoring provider performance and the strategies proposed to be implemented including, at a minimum, ongoing educational opportunities and corrective action plans to provide needed support.

3. The vendor should describe the strategies the vendor 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.

4. The vendor should describe their proposed strategies for partnering with stakeholders (e.g. community-based service providers, LPHAs, schools, state agency's, FQHCs, consumer groups, etc.).

5. The vendor should describe their proposed process for monitoring and tracking complaints, grievances, appeals, and denials.

6. The vendor should provide a listing, description, and conditions under which the vendor will offer additional health benefits to its members. Examples of additional health benefits are NEMT for members who do not have NEMT as part of their benefit package; or sponsorship in youth programs such as Boy Scouts or YMCA. The vendor shall understand and agree that award of a contract does not constitute the state agency's approval or acceptance of the proposed additional health benefits.

Provider Services

Addendum 02 revised a word in the following question.

1. The vendor should describe their 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 vendor's response should include how the vendor 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, care management, and reduction of racial and ethnic disparities to improve health status.

2. The vendor should describe their proposed training and education activities for providers, including the 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, care management, and reduction of racial and ethnic health care disparities to improve health status.

3. The vendor should describe their activities proposed to monitor and track compliance with the provider toll-free telephone line performance standards required herein.

EXHIBIT C

TECHNICAL PROPOSAL - PROPOSED METHODOLOGY AND APPROACH – GENERAL PLAN

Member Services

1. The vendor should describe how the vendor proposes to update members as information in the member handbook changes. The description should address, at a minimum, the vendor's strategies to ensure that members are informed of changes in a timely manner. The description should also include how the vendor 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, care management, and reduction of racial and ethnic health care disparities to improve health status.

2. The vendor should describe their 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 vendor's response should include how the vendor 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, care management, and reduction of racial and ethnic health care disparities to improve health status.

3. The vendor should describe their proposed activities to monitor and track compliance with the member services toll-free telephone line performance standards described herein.

4. The vendor should describe how the vendor proposes to route calls among staff to ensure timely and accurate response to member inquiries, including procedures for referring the calls to supervisors/managers.

General Methodology and Approach Questions

1. Economic Impact to Missouri - The vendor should describe the economic advantages that will be realized as a result of the vendor performing the required services. The vendor should respond to the following:

    - 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.

    - Provide a description of the economic impact returned to the State of Missouri through tax revenue obligations.

    - 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.

Addendum 02 revised Exhibit D

EXHIBIT D

TECHNICAL PROPOSAL – QUALITY – GENERAL PLAN

Directions for Vendor - The vendor should provide the information requested from the vendor's Quality, especially that related to the General Plan requirements of the RFP. The vendor's response should align with the requirements specified in Section 2, Scope of Work – General Plan, and Section 4 - Contractual Requirements.
******REMINDER – The combined Technical Proposal for the General Plan should be no longer than 450 pages.***

The vendor should provide the following information addressing quality care and improving patient outcomes. The vendor should add additional lines to each table or make copies of this form as necessary.

NCQA Accreditation: If the vendor is NCQA-accredited, the vendor should list the states in which the vendor holds accreditation and provide the following information for each state. The vendor should also include a copy of the applicable NCQA report cards for the vendor. The vendor should also include information regarding the vendor's parent organization, affiliates, and subsidiaries.

Addendum 02 revised the table below.

Health Plan *Name:*	***Health Plan Rating:***	***Status and Last Update:***	***Insurance and Product Type:***	***State:***

Addendum 02 revised the instructions and the table below.

If the vendor has ever had its accreditation status (e.g., NCQA, URAC, or AAAHC) in any state, for any product line adjusted down, ***not accredited, expired, or denied,*** the vendor should identify the state and product line and provide an explanation. The vendor should include information regarding the vendor's parent organization, affiliates, and subsidiaries.

Health Plan *Name:*	**Type of Accreditation (e.g. NCQA, URAC, or AAAHC):**	**Original and Adjusted Accreditation Status, including dates:**	***Not Accredited, Expired, or Denied:***	**Product *Type:***	**Explanation**

EXHIBIT D, CONTINUED…

TECHNICAL PROPOSAL – QUALITY – GENERAL PLAN

Addendum 02 revised the instructions and the table below.

HEDIS Measures: For each of the vendor's Medicaid contracts, the vendor should provide the vendor's results for the following HEDIS measures for the years 2018, 2019, and 2020 ***on a statewide basis***. If the results for a particular HEDIS measure or year are not available, the vendor should provide the results that are available. If the vendor does not have the results for a Medicaid product line in a state where the vendor has held a Medicaid contract, the vendor should provide the results for the vendor's Medicare (preferred) or commercial product line in that state (and indicate which product line the results apply to). If the vendor does not have results for every measure or year, the vendor should provide the results that are available. If the vendor has measures for a Medicare or commercial product line in a particular state, but does not have such information for the vendor's Medicaid contract, the vendor should provide that information. The vendor should explain any missing information (measure, year, or Medicaid contract).

HEDIS Measures:	*HEDIS 18*	*HEDIS 19*	*HEDIS 20*
Ambulatory Care (AMB) - ED Visits			
Annual Dental Visits (ADV) - Total			
Asthma Medication Ratio (AMR) - Total			
Follow-up After Hospitalization for Mental Illness (FUH):			
✓ *30-Day Follow-Up*			
Prenatal and Postpartum Care (PPC):			
✓ *Timeliness of Prenatal Care*			
✓ *Postpartum Care*			
Adolescent Well-Care Visits (AWC)			
Child & Adolescent Well-Care Visits (WCV):			
✓ *3-11 years*			
✓ *2-17 years*			
✓ *18-21 years*			
✓ *Total*			
Well-Child Visits in the First 15 Months of Life (W15):			
✓ *Six or more well-child visits*			
Well Child Visits in the First 30 Months of Life (W30):			
✓ *Well-Child Visits in the First 15 Months*			
✓ *Well-Child Visits for Age 15 Months-30 Months*			

EXHIBIT D, CONTINUED…

TECHNICAL PROPOSAL – QUALITY – GENERAL PLAN

Health Outcome Improvement Strategies: The vendor should provide the proposed strategies for improving the Managed Care Program population health outcomes for the following HEDIS measures for the following periods.

HEDIS Measures	*Original Contract Period*	*First Renewal Period*	*Second Renewal Period*	*Third Renewal Period*	*Fourth Renewal Period*
Ambulatory Care (AMB) – ED Visits					
Annual Dental Visits (ADV) - Total					
Asthma Medication Ratio (AMR) - Total					
Follow-up After Hospitalization for Mental Illness (FUH):					
✓ ***30-Day Follow-Up***					
Prenatal and Postpartum Care (PPC):					
✓ ***Timeliness of Prenatal Care***					

HEDIS Measures	*Original Contract Period*	*First Renewal Period*	*Second Renewal Period*	*Third Renewal Period*	*Fourth Renewal Period*
✓ *Postpartum Care*					
Child & Adolescent Well-Care Visits (WCV):					
✓ *3-11 Years*					
✓ *12-17 Years*					
✓ *18-21 Years*					
✓ *Total*					
Well Child Visits in the First 30 Months of Life (W30):					
✓ *Well-Child Visits in the First 15 Months*					
✓ *Well-Child Visits for Age 15 Months-30 Months*					

EXHIBIT D, CONTINUED…

TECHNICAL PROPOSAL – QUALITY – GENERAL PLAN

Quality Assessment and Improvement Programs: The vendor should describe the Quality Assessment and Improvement Programs proposed to be implemented. The vendor should describe how the proposed Quality Assessment and Improvement Programs will expand the quality improvement services beyond what the vendor is currently providing and should explain the difference between the vendor's current programs and the proposed programs. The vendor should also detail how the proposed Quality Assessment and Improvement Program will improve the health care status of the Managed Care Program population. The vendor should describe the rationale for selecting the particular programs including the identification of particular health care problems and issues within the Managed Care Program population that each program will address and the underlying cause(s) of such problems and issues. The vendor should understand and agree that award of contract does not constitute approval or acceptance of the proposed Quality Assessment and Improvement Programs.

Quality Assessment and Improvement Program	
Describe how the proposed program will expand the quality improvement services beyond what the vendor is currently providing and explain the difference between the vendor's current programs and the proposed program	
Detail how the proposed program will improve the health care status of the MO HealthNet Managed Care Program population	
Describe the rationale for selecting the particular program including the identification of particular health care problems and issues within the MO HealthNet Managed Care Program population that the program will address and the underlying cause(s) of such problems and issues	

EXHIBIT D, CONTINUED…

TECHNICAL PROPOSAL – QUALITY – GENERAL PLAN

Focus Study(ies)/Quality Assessment & Improvement Programs: The vendor should provide the following information related to focus study(ies) performed, any quality assessment and improvement programs involved in, and/or any other improvements or related projects the vendor has implemented or been involved with. The vendor 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 2015):	
Cost Savings Realized:	
Process Efficiencies:	
Improvement to Member Health Status:	
Identification of Issues and Root Causes:	

Addendum 02 revised Exhibit E.

EXHIBIT E

TECHNICAL PROPOSAL – ACCESS TO CARE AND CARE MANAGEMENT – GENERAL PLAN

Directions for Vendor - The vendor should provide the information requested from the vendor's Access to Care and Care Management, especially that related to the General Plan requirements of the RFP. The vendor's response should align with the requirements specified in Section 2, Scope of Work – General Plan, and Section 4 - Contractual Requirements. ******REMINDER – The combined Technical Proposal for the General Plan should be no longer than 450 pages.***

Primary Care - The vendor should provide the following information specific to how the vendor will ensure member access to primary care services.

Primary Care		
1.	The vendor should explain how the vendor's orientation programs, educations strategies, and interventions for PCP and members differ in urban areas and rural areas.	
2.	The vendor should describe the vendor's approach to achieve optimal outcomes given regional demographic differences. The vendor should refer to Attachment 1, MO HealthNet Managed Care Eligibility Groups.	
3.	The vendor should describe the proposed targeted initiatives related to Primary Care to meet the requirements of the RFP. The vendor should describe how the vendor will meet members' Primary Care needs in a coordinated and integrated manner per the RFP requirements regarding provider network, access standards, quality assessment and improvement, care management (CM), and disease management (DM).	
4.	The vendor should address how the vendor will utilize telemedicine in rural areas, including specific strategies that will be used, purposes for which telemedicine will be used, targeted populations and conditions, and providers.	

Primary Care		
5.	The vendor should identify the vendor's strategies to utilize PCPs to identify, reduce, and monitor inappropriate hospital readmissions. The vendor should describe the extent to which these strategies will differ according to populations, geographic locations, and health conditions.	
6.	The vendor should identify the tools the vendor will use to monitor emergency room utilization. The vendor should describe the measures the vendor proposes to combat/reduce emergency room overuse. The vendor should describe specific measures the vendor will take during the original contract period and each renewal option period.	
7.	The vendor should describe how the vendor will utilize safety net providers (e.g., FQHCs, public health departments, CMHCs) to facilitate access to primary care services (including measures for identifying when safety net providers are needed and outreach to public providers). The vendor should also address how these strategies will differ among the urban areas and rural areas.	
Addendum 02 deleted and added language in the question below.		
8.	The vendor should describe how tertiary care providers will be available 24 hours per day ***for Primary Care providers*** in the regions. If the vendor does not have a full range of tertiary care providers, the vendor should describe how for Primary Care services will be provided including transfer protocols and arrangements with out of network facilities.	
9.	The vendor should explain the cost effective approaches the vendor will implement, aside from transportation, to ensure that members in remote counties are able to access primary care. The vendor should describe the strategies the	

Primary Care		
	vendor will implement to outreach to PCPs. The vendor should also describe how the vendor will monitor the effectiveness of the proposed strategies.	
10.	The vendor should provide any additional information that highlights and differentiates the vendor's plan for ensuring primary care access for its members, only to the extent that the information has not been presented elsewhere in the proposal.	

Specialty Care - The vendor should provide the following information specific to how the vendor will ensure member access to specialty care services.

Specialty Care		
1.	The vendor should explain how the vendor's orientation programs, educations strategies, and interventions for specialty care providers and members differ in urban areas and rural areas.	
2.	The vendor should describe the vendor's approach to achieving optimal outcomes given regional demographic differences. The vendor should refer to Attachment 1, MO HealthNet Managed Care Eligibility Groups.	
3.	The vendor should describe the targeted initiatives proposed related to specialty care to meet the requirements of the RFP. The vendor should describe how the vendor will meet members' specialty care needs in a coordinated and integrated manner per the RFP requirements regarding provider network, access standards, quality assessment and improvement, care management (CM), and disease management (DM).	
4.	The vendor should address how the vendor will utilize telemedicine in rural areas, including specific strategies that will be used, purposes for	

Specialty Care		
	which telemedicine will be used, targeted populations and conditions, and providers.	
5.	The vendor should identify the vendor's strategies to identify, reduce, and monitor inappropriate hospital readmissions through specialty care providers. The vendor should describe extent to which these strategies will (1) differ according to populations, geographic locations, and health conditions, and (2) be integrated with primacy care providers.	
6.	The vendor should identify the tools the vendor will use to monitor emergency room utilization through specialty care providers. The vendor should describe to what extent these tools will (1) differ according to populations, geographic locations, and health conditions, and (2) be integrated with primacy care providers. The vendor should also describe the measures the vendor proposes to combat/reduce emergency room overuse for specialty care conditions, including those during the original contract period and potential renewal periods.	
7.	The vendor should describe how the vendor will utilize PCPs including safety net providers (e.g., FQHCs, public health departments, CMHCs) to facilitate access to specialty care services (including measures for identifying when safety net providers are needed and outreach to public providers). The vendor should also address how these strategies will differ among the urban areas and rural areas.	

Specialty Care		
8.	The vendor should describe how tertiary care providers for specialty care, including trauma centers, burn centers, level III (high-risk) nurseries, rehabilitation facilities, and medical sub-specialists will be available 24 hours per day in the regions. If the vendor does not have a full range of tertiary care providers, the vendor should describe how specialty care services will be provided including transfer protocols and arrangements with out of network facilities.	
9.	The vendor should explain the cost effective approaches the vendor will implement, aside from transportation, to ensure that members in remote counties are able to access specialty care. The vendor should describe the strategies the vendor will implement to outreach to specialty care providers. In addition, the vendor should describe how the vendor 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 vendor should also describe how the vendor will monitor the effectiveness of the proposed strategies.	
10.	The vendor should provide any additional information that highlights and differentiates the vendor's plan for ensuring specialty care access for its members, only to the extent that the information has not been presented elsewhere in the proposal.	

Dental Services - The vendor should provide the following information, specific to how the vendor will ensure access to dental services.

Dental Services		
1.	The vendor should explain how the vendor's orientation programs, educations strategies, and interventions for Dental Services providers and members differ in urban areas and rural areas.	
2.	The vendor should describe the vendor's approach to achieve optimal outcomes given regional demographic differences. The vendor should refer to Attachment 1, MO HealthNet Managed Care and Related Eligibility Groups.	
3.	The vendor should describe the targeted initiatives proposed related to Dental Services to meet the requirements of the RFP. The vendor should describe how the vendor will meet members' Dental Services needs in a coordinated and integrated manner per the RFP requirements regarding provider network, access standards, quality assessment and improvement, care management (CM), and disease management (DM).	
4.	The vendor should address how the vendor will utilize telemedicine in rural areas, including specific strategies that will be used, purposes for which telemedicine will be used, targeted populations and conditions, and providers.	
5.	The vendor should identify the tools the vendor will use to monitor emergency room utilization for dental services. The vendor should describe the measures the vendor proposes to combat/reduce emergency room overuse for dental services. The vendor should describe specific measures the vendor will take during the original contract period and each renewal option period.	
6.	The vendor should describe how the vendor will utilize primary care including safety net providers (e.g., FQHCs, public health	

Dental Services		
	departments, CMHCs) to facilitate access to needed dental services (including measures for identifying when safety net providers are needed and outreach to public providers). The vendor should also address how these strategies will differ among the urban areas and rural areas.	
7.	The vendor should describe how the vendor will ensure that children receive needed dental services. The vendor should describe how the vendor's efforts will differ among urban areas and rural areas.	
8.	The vendor should describe how the vendor will ensure that adults receive needed dental services. The vendor should describe how the vendor's efforts will differ among urban areas and rural areas.	
9.	The vendor should describe how tertiary care providers for dental services will be available 24 hours per day in the regions. If the vendor does not have a full range of tertiary care providers, the vendor should describe how dental services will be provided including transfer protocols and arrangements with out of network facilities.	
10.	The vendor should explain the cost effective approaches the vendor will implement, aside from transportation, to ensure that members in remote counties are able to access dental services. The vendor should describe the strategies the vendor will implement to outreach to dental providers. In addition, the vendor should describe how the vendor 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 dental health providers. The vendor should also	

Dental Services		
	describe how the vendor will monitor the effectiveness of the proposed strategies.	
11.	The vendor should provide any additional information that highlights and differentiates the vendor's plan for ensuring dental care access for its members, only to the extent that the information has not been presented elsewhere in the proposal.	

Behavioral Health - The vendor should provide the following information specific to how the vendor will ensure access to behavioral health services.

Behavioral Health		
1.	The vendor should explain how the vendor's orientation programs, educations strategies, and interventions for Behavioral Health providers and members differ in urban areas and rural areas.	
2.	The vendor should describe the vendor's approach to achieve optimal outcomes given regional demographic differences. The vendor should refer to Attachment 1, MO HealthNet Managed Care and Related Eligibility Groups.	
3.	The vendor should describe the targeted initiatives proposed related to Behavioral Health Care to meet the requirements of the RFP. The vendor should describe how the vendor will meet members' Behavioral Health Care needs in a coordinated and integrated manner per the RFP requirements regarding provider network, access standards, quality assessment and improvement, care management (CM), and disease management (DM).	
4.	The vendor should address how the vendor will utilize telemedicine in rural areas, including specific strategies that will be used, purposes for which telemedicine will be used, targeted populations and conditions, and providers.	

Behavioral Health		
5.	The vendor should identify the vendor's strategies to identify, reduce, and monitor inappropriate behavioral health related hospital readmissions. The vendor should describe to what extent these strategies will (1) differ according to populations, geographic locations, and health conditions, and (2) be integrated with primacy care providers.	
6.	The vendor should identify the tools the vendor will use to monitor emergency room utilization for behavioral health conditions. The vendor should describe to what extent these tools will (1) differ according to populations, geographic locations, and health conditions, and (2) be integrated with primacy care providers. The vendor should describe the measures the vendor proposes to combat/reduce emergency room overuse for behavioral health conditions. The vendor should describe specific measures the vendor will take during the original contract period and each renewal option period.	
7.	The vendor should describe how the vendor will utilize PCPs including safety net providers (e.g., FQHCs, public health departments, CMHCs) to facilitate access to needed behavioral health services (including measures for identifying when safety net providers are needed and outreach to public providers). The vendor should also address how these strategies will differ among the urban areas and rural areas.	
8.	The vendor should describe how the vendor will ensure that children have access to child psychiatrists and psychologists.	
9.	The vendor should explain the specific measures the vendor will take to ensure that children and women with substance use diagnoses are screened for depression and other co-occurring behavioral health conditions. The	

Behavioral Health		
	vendor should describe how its efforts will differ among urban areas and rural areas.	
10.	The vendor should describe how tertiary care providers for Behavioral Health services will be available 24 hours per day in the regions. If the vendor does not have a full range of tertiary care providers, the vendor should describe how Behavioral Health services will be provided including transfer protocols and arrangements with out of network facilities.	
11.	The vendor should explain the cost effective approaches the vendor will implement, aside from transportation, to ensure that members in remote counties are able to access behavioral health services. The vendor should describe the strategies the vendor will implement to outreach to behavioral health providers. In addition, the vendor should describe how the vendor 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 behavioral health providers. The vendor should also describe how the vendor will monitor the effectiveness of the proposed strategies.	
12.	The vendor should provide any additional information that highlights and differentiates the vendor's plan for ensuring behavioral health care access for its members, only to the extent that the information has not been presented elsewhere in the proposal.	

Care Management (CM) - The vendor should provide the following information specific to how the vendor will provide CM.

Care Management (CM)		
1.	The vendor should describe how the vendor's care management program will address the following: a. Coordination and follow-up of ambulatory and inpatient care/service needs; b. Referrals to and coordination with community-based resources/services that provide that are not covered by the vendor; c. The process for receiving and sharing pertinent information and interfacing with the member, the member's PCP, and other relevant providers, other insurers, and as appropriate, the member's family, to promote continuation of care and coordination of services; d. Involvement of the member and caregivers in decisions regarding care and/or the member's care plan; e. Applying clinical knowledge to the member's condition; f. Care coordination not addressed above; g. Health promotion services h. Comprehensive transitional care; i. Individual and family support activities; j. Disease Management (DM); and k. Referrals to community and social supports.	
Addendum 02 deleted the question below.		
2.	***DELETED.***	
3.	The vendor should describe the staffing and organizational structure of the vendor's CM unit. The vendor may use flow charts and/or organizational charts in its response. At a minimum, the vendor should include the following in its response: a. The title, function, and responsibilities of each member of the CM unit;	

	b. How the vendor will ensure a diverse and culturally sensitive staff; and c. Strategies the vendor will employ to manage caseloads and minimize staff turnover.	
4.	The vendor should identify any measureable results in terms of clinical outcomes and program savings that have resulted from the vendor's CM and/or service coordination initiatives.	
5.	The vendor should provide an actionable plan to coordinate and manage care for identified over utilizers of avoidable emergency department and hospital services and medically complex individuals and how the vendor will track the process, evaluate outcomes, and implement evidence-based change.	
6.	The vendor should describe how the vendor will ensure appropriate CM and coordinated behavioral health services with the delivery of other services under the EPSDT benefit.	
Addendum 02 deleted and added language to the question below.		
7.	The vendor should describe the vendor's approach/strategy for ensuring integrated care management systems and programs for physical health and behavioral health will be met ***prior to the implementation*** of a contract resulting from this RFP. The vendor's description should include detail regarding the integrated CM platforms for sharing data and notes between physical and behavioral health care managers and whether or not the care managers are co-located and if not, the vendor's system for working together in an effective manner. If the vendor does not describe integrated CM systems and programs currently in use, the vendor should detail the exact nature of the integrated CM systems and programs, the state in which the integrated CM systems and programs exist, and the length of time in which the integrated	

	CM system s and program have been in effect. The vendor should provide a narrative detailing how integration between physical health and behavioral health CM staff will work within the CM program.	

Addendum 02 revised Exhibit F.

EXHIBIT F

TECHNICAL PROPOSAL – MEDICAID REFORM AND TRANSFORMATION – GENERAL PLAN

Directions for Vendor – The vendor should provide the information requested of the vendor's Medicaid Reform and Transformation, especially that related to the General Plan requirements of the RFP. The vendor's response should align with the requirements specified in Section 2, Scope of Work – General Plan, and Section 4 - Contractual Requirements. ******REMINDER – The combined Technical Proposal for the General Plan should be no longer than 450 pages.***

In presenting the Medicaid Reform and Transformation, the vendor should discuss each of the following areas:

Personal Responsibility

1. The vendor should submit a draft of the vendor's member incentive programs. The vendor shall understand and agree that award of a contract does not constitute the state agency's approval or acceptance of the vendor's member incentive programs. For each member incentive program proposed, the vendor should provide the following information:

    a. What the proposed member incentives are;
    b. How the incentives are related to the vendor's quality incentives;
    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 vendor will promote the member incentive program;
    g. The anticipated cost of the member incentive program; and
    h. If applicable, a description of the intent to which the vendor is currently offering the member incentive program.

State Provider Incentive Program

1. The vendor should provide a description of the vendor'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, at a minimum, the following provider types: primary care, behavioral health, CMHCs, FQHCs, RHCs, licensed clinical social workers (LCSWs), etc. If applicable, the vendor should describe the extent to which the vendor is currently offering state provider incentive programs.

Accountability and Transparency

1. Fraud and Abuse – The vendor should describe their internal controls, policies, and procedures to prevent, coordinate, detect, investigate, enforce, and report fraud, waste, and abuse. The vendor 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 in which instances it should be reported.

2. Transparency – The vendor should describe how the vendor will meet Operational Data Reporting contractual requirements.

Local Community Care Coordination Program (LCCCP)

1. The vendor should submit the vendor's LCCCP application and program model. Such program may use any delivery model that focuses on providing CM, care coordination, and DM through local healthcare providers. Models may include ACOs, PCMHs, PCCM, subcapitated entities, a combination thereof, or other similar models. Providers within these applicable models may include, at a minimum, PCPs/specialties/groups, CMHCs, FQHCs, behavioral health providers/groups, or other provider types or groups that coordinate and manage the care of members. The vendor shall understand and agree that the award of a contract does not constitute the state agency's approval or

EXHIBIT F, CONTINUED…

TECHNICAL PROPOSAL – MEDICAID REFORM AND TRANSFORMATION – GENERAL PLAN

acceptance of the vendor's LCCCP, and that the vendor's LCCCP program will undergo further review and approval upon contract award.

2. The vendor should describe the extent to which the vendor is currently in arrangements with local providers (i.e. PCPs, behavioral health providers, MCHCs, FQHCs, RHCs, LCSWs, etc.), to provide the type of services that would be potentially approved by the state agency as a LCCCP.

3. The vendor should describe how the vendor proposes to educate providers about the program requirements and provider expectations for DM, care coordination, CM, LCCCP, and the state agency's health home programs.

4. The vendor should describe how the vendor proposes to (1) work with providers to establish LCCCPs, (2) monitor program outcomes and effectiveness of interventions, and (3) determine how to make improvements to LCCCP(s).

5. The vendor should describe how they plan to inform members about the LCCCP(s).

6. The vendor should provide their plan for sharing any claims data, CM data, and other data available with the providers within the vendor's chosen model to effectively meet the obligations of the vendor's LCCCP.

7. The vendor should describe how the vendor will ensure that there is no duplication of services between the CM, care coordination, DM, LCCCPs, and state agency health home programs.

8. If applicable, the vendor should describe to what extent the vendor is currently offering LCCCPs.

Value-Based Purchasing

Addendum 02 added language to the question below.

1. The vendor should describe Value-Based Purchasing Models and Strategies in accordance with the value-based purchasing requirements herein. ***Innovative provider payment strategies that move beyond the fee-for-service payment continuum such as provider incentives, risk sharing arrangements, episode payments, etc. will be considered Value-Based Models or Purchasing Strategies as long as all requirements specified herein are met.*** Such models and strategies should include approaches for collaboration among all awarded health plans. The vendor should address each element in the table below when describing proposed Value-Based Purchasing Models and Strategies:

Framework for Value-Based Model and Purchasing Strategy Proposals	
✓ Description of Value-Based Model(s) and Purchasing Strategy(ies) objectives	Provide a detailed description of the Value-Based Model(s) and Purchasing Strategy(ies), how it differs from traditional service delivery and/or payments, and the goals and objectives the vendor seeks to achieve through the model/strategy. The vendor should describe how these goals and objectives align with state agency Quality Strategy goals.
✓ Identify specific populations and services included in the model/strategy	Describe the populations and services/providers that would be included in the model/strategy. The proposal may be limited to certain services (e.g. hospital inpatient or outpatient services, physician services, etc.), specified populations and/or subpopulations (e.g. individuals with chronic conditions), and/or other categories (e.g. rural geographic area) as appropriate for the Value-Based Model and Purchasing Strategy. Populations eligible for inclusion in Value-Based Purchasing are those listed for the General Plan herein.

Framework for Value-Based Model and Purchasing Strategy Proposals	
	Services may include Value-Added Benefits, including benefits and strategies that would support social determinants of health.
✓ Identify role of care management strategies, as applicable	The vendor should indicate how the proposed model/strategy relies on care management and care transition strategies including collaboration with community based organizations, community health workers, and LCCCPs to leverage synergies at the local level to identify and address social determinants of health supporting care transition, in particular.
✓ Identify role of health information technology/health information exchange (HIT/HIE), as applicable	The vendor should identify what HIT /HIE components are necessary for successful implementation of the model. This could include new capabilities and strategies to address interoperability.
✓ Coordination and collaboration with existing Value-Based Purchasing and Quality Initiatives	The vendor should specify how they will coordinate and collaborate with existing, relevant Value-Based Purchasing and Quality Initiatives in the state. This could include models that the vendor may have in place for commercial or Medicare members, ACOs, or other existing models.
✓ Identify whether the model is proposed as a pilot program or proposed for statewide implementation, and whether the vendor has existing experience with the proposed model in Missouri or in another state	The vendor should identify providers that are participating (if this model is already implemented) or if the vendor has identified interested providers. If the proposed model has already been implemented by the vendor in another market, the vendor should indicate the specific market and include a description of outcomes associated with the existing model. The vendor should also include a stakeholder engagement strategy for areas where the model will be implemented.
✓ Describe the payment model being employed	The vendor should identify how the payment model incentivizes the outcomes the vendor is seeking. The vendor should describe whether the proposed model includes upside and downside risk (and over what timeline), includes incentives or an alternative payment strategy such as a bundled payment, global payment, or other alternative to FFS reimbursement to drive outcomes. The vendor should also describe the reasonableness of any downside risk for providers.
✓ Identify the proposed metrics, outcomes, or other measurements that the vendor will use to (1) determine the payment methodology, if applicable; (2) evaluate quality improvement; and (3) evaluate the effectiveness of the model to the vendor, provider, and member	The vendor should describe why the specific metrics/measures were selected and how they relate to the model, quality, and health outcomes. The vendor should describe how they would monitor provider performance and the impact on members. Additionally, the vendor should describe how they will provide data, outcomes, and evaluation of model effectiveness to the state. If the proposed model could skew any performance measures otherwise reported, the vendor should identify the interdependencies for state consideration. The vendor should also describe a stakeholder engagement plan for receiving input in the development of performance metrics.
✓ Identify the total number of members expected to participate in the model/strategy, the network providers expected to participate, and when the model/strategy is expected to start	The vendor should describe a proposed implementation timeline that addresses research, development, provider engagement or enrollment in the model, or both; total number of providers targeted/enrolled in the model and roll-out (including phase-in and staggered deployment). The vendor should understand and agree that such timeline must assume full deployment within 12 months of the implementation date of the contract.

2. The vendor should address each Example of Value-Based Models and Purchasing Strategies identified herein, including how each is employed in an innovative manner.

   ✓ In addition, each example addressed should describe approaches to promote use and collaboration among different provider types within the delivery system such as FQHCs, CCBHOs, and CMHCs.

   ✓ If the vendor does not have a proposal related to an example of a Value-Based Purchasing Model identified herein, the vendor should explain why.

3. The vendor should indicate whether the Value-Based Purchasing Models proposed should be considered for adoption across all selected health plans, and why or why not.

EXHIBIT G

TECHNICAL PROPOSAL – EXECUTIVE SUMMARY – SPECIALTY PLAN

Directions for Vendor - The vendor should provide the information requested from the vendor's Executive Summary, especially those related to the Specialty Plan requirements of the RFP. The vendor's response should align with the requirements specified in Section 3, Scope of Work – Specialty Plan, and Section 4 - Contractual Requirements.

Information on the executive summary will not be evaluated or scored, but may be reviewed by evaluators and may be used in whole or in part in public communications following the award. ***This section should be limited to 5 pages.***

The combined Technical Proposal for the Specialty Plan should be no longer than 175 pages.

In presenting the vendor's Executive Summary, the vendor should discuss the following areas:

1. The vendor should provide an overview of the vendor, the vendor's relevant experience, and a high-level description of the vendor's overall plan to improve health outcomes for individuals enrolled in the Specialty Plan.

EXHIBIT H

TECHNICAL PROPOSAL – ORGANIZATIONAL EXPERIENCE – SPECIALTY PLAN

Directions for Vendor – The vendor should provide the information requested from the vendor's Organizational Experience related to past/current performance, especially that related to the Specialty Plan requirements of the RFP. The vendor's response should align with the requirements specified in Section 3, Scope of Work – Specialty Plan, and Section 4 - Contractual Requirements.
******REMINDER – The combined Technical Proposal for the Specialty Plan should be no longer than 175 pages.***

In presenting the vendor's Organizational Experience – Specialty Plan, the vendor should discuss the following areas:

1. The vendor should describe the vendor's experience serving the populations covered under the Specialty Plan in Missouri and other states within the past five years, and identify the associated contract.

2. Contracts Terminated/Not-Renewed – The vendor should identify whether the vendor has had a contract terminated or nor renewed within the past five years. If so, the vendor should describe the reason(s) for the termination/non-renewal and the parties involved, and should provide the address and telephone number of the client. If the contract was terminated/not-renewed based upon the vendor's performance, the vendor should describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. The vendor's response should address the vendor's parent organization, affiliates, and subsidiaries conducting Medicaid or other state federal health business.

Vendor's Terminated/Non-Renewed Contracts:	Contracting Entity, including Address and Telephone Number:	Reason for Termination/Non-Renewal, including any Corrective Actions Taken to Prevent Future Occurrence of Problem

3. The vendor should identify, for contracts serving populations similar to those populations covered under the Specialty Plan, whether a contracting party found the vendor to be in breach of any of the vendor's contracts within the past five years. If so, the vendor should (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 vendor's control, (2) if a corrective action plan was imposed, the vendor should describe the steps and timeframes in the corrective action plan and whether the corrective action plan was completed, (3) if a sanction or liquidated damage was imposed, the vendor should describe the sanction/liquidated damage, including the amount of any monetary sanction/damage, and (4) if the breach was the subject of an administrative proceeding or litigation, the vendor should indicate the result of the proceeding/litigation. The vendor's response should address the vendor's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

4. Innovative Experience - Based upon the vendor's experience managing benefits and populations similar to those covered under the Specialty Plan, the vendor should provide an example of an innovative and effective approach used by the vendor in similar programs, the resulting outcomes, and how the vendor will use its experience to achieve Specialty Plan program goals and objectives. ***The vendor should limit this description to no longer than five pages.***

5. Current Subcontract Relationships - The vendor should identify any contracts in which the proposed health care service subcontractors are currently providing services for the vendor. The vendor should also 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

Health Service Subcontractor	Contract	Description of Service Provided	State Where Services are Being Provided

EXHIBIT H, CONTINUED….

TECHNICAL PROPOSAL – ORGANIZATIONAL EXPERIENCE – SPECIALTY PLAN

6. The vendor should provide the following information for six contracts relative to the services required herein. The vendor should copy and complete this form documenting the vendor and subcontractor's current/prior experience considered most relevant to the services required herein, including the provision of physical health and behavioral health services.

Vendor Name or Subcontractor Name: _____ (if reference is for a Subcontractor):					
Reference Information (Current/Prior Services Performed For:)					
Name, Title, Address, and Contact Information (telephone 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 Income 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 vendor 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 I

TECHNICAL PROPOSAL - PROPOSED METHODOLOGY AND APPROACH – SPECIALTY PLAN

Directions for Vendor - The vendor should provide the information requested from the vendor's Methodology and Approach, especially that related to the Specialty Plan requirements of the RFP. The vendor's response should align with the requirements specified in Section 3, Scope of Work – Specialty Plan, and Section 4 - Contractual Requirements. ******REMINDER – The combined Technical Proposal for the Specialty Plan should be no longer than 175 pages.***

In presenting the Proposed Methodology and Approach, the vendor should discuss the following areas:

Program Administration – Specialty Plan Monitoring, Program and Provider Monitoring, and Prescriber Oversight

1. The vendor should describe the vendor's methods, infrastructure, systems, and procedures for monitoring, evaluating, and continuously improving the vendor's effectiveness in coordinating and delivering services, meeting contractual expectations, and improving the health outcomes of the Specialty Plan population. ***The vendor should limit this response to no longer than six pages.***

2. The vendor should describe the vendor's proposed methods for monitoring and driving Specialty Plan provider performance improvement. ***The vendor should limit this response to no longer than five pages.***

3. The vendor should describe the vendor's methods, infrastructure, systems, and procedures for monitoring to identify and address prescriber-related concerns (e.g. over-prescribing, poly-pharmacy). The vendor should include how the vendor will collaborate with state agencies, including MHD, CD, DYS, DMH, and the Center for Excellence to fulfill expectations under Missouri's Psychotropic Medication Settlement. ***The vendor should limit this response to no longer than four pages.***

Provider Services – Communication Strategies, Eligibility and Enrollment Issue Resolution

1. The vendor should describe the communication strategies the vendor will use to educate providers about the Specialty Plan, the needs of Specialty Plan members, and how the requirements of the Specialty Plan and the needs of Specialty Plan members differ from those members under the General Plan. The vendor should include the vendor's approach for evaluating the ongoing effectiveness of its communication strategies. ***The vendor should limit this response to no longer than four pages.***

2. The vendor should describe the training topics, content, and delivery modalities the vendor will offer to Specialty Plan providers. ***The vendor should limit this response to no longer than five pages.***

Member Services – Communication Strategies, Eligibility and Enrollment Issue Resolution

1. The vendor should describe the communication strategies the vendor will use to educate members, families, and resource providers about the Specialty Plan, including: the available benefits and how to access them; the availability of CM and DM services; member rights; how to resolve concerns, questions and problems; how to access communication assistance; and available providers in the vendor's network. The vendor should include the vendor's approach for evaluating the ongoing effectiveness of its communication strategies. ***The vendor should limit this response to no longer than four pages.***

2. The vendor should describe how eligibility and enrollment for Specialty Plan members may change rapidly due to changes in the members' custodial status in the foster care and juvenile justice systems. The vendor should describe the vendor's approach to resolve issues related to short-term eligibility/enrollments in the Specialty Plan and how the vendor will ensure that resulting eligibility/enrollment discrepancies do not negatively impact the continuity of care for members. ***The vendor should limit this response to no longer than four pages.***

Addendum 02 revised Exhibit J.

EXHIBIT J

TECHNICAL PROPOSAL - QUALITY – SPECIALTY PLAN

Directions for Vendor – The vendor should provide the information requested from the vendor's Quality, especially that related to the Specialty Plan requirements of the RFP. The vendor's response should align with the requirements specified in Section 3, Scope of Work – Specialty Plan, and Section 4 - Contractual Requirements.
******REMINDER – The combined Technical Proposal for the Specialty Plan should be no longer than 175 pages.***

In presenting the vendor's Quality, the vendor should discuss the following areas:

Non-HEDIS Metrics

1. The vendor should describe the non-HEDIS metrics the vendor will use to determine the effectiveness of its program to improve the health outcomes of its Specialty Plan members. The vendor should include how the vendor will calculate the baseline measurement and the vendor's approach for establishing performance goals. ***The vendor should limit this response to no longer than seven pages.***

Specialty Plan Quality Program

1. The vendor should describe the structure, leadership, and activities of the vendor's Specialty Plan quality program. The vendor's description should include how the structure, leadership, and quality activities for the Specialty Plan will interface with those of the General Plan. ***The vendor should limit this response to no longer than seven pages.***

Clinical Practice Guidelines

Addendum 02 added a word to the question below.

1. The vendor should ***describe*** the clinical practice guidelines the vendor will promote for delivering services to Specialty Plan members. The vendor's response should include the vendor's strategy for disseminating and evaluating the implementation of clinical practice guidelines necessary to transform provider practices. The vendor's description should include an example of a clinical practice guideline successfully implemented in a contract with populations similar to those in the Specialty Plan. ***The vendor should limit this response to no longer than five pages.***

Member, Provider, and Family Stakeholder Advisory Council

1. The vendor should describe its approach to developing and supporting a Member, Family, and Stakeholder Advisory Council for the Specialty Plan. The vendor description should include how the vendor will use feedback from the Council to drive and support its quality activities to improve health outcomes and member/family satisfaction. The vendor's response should include the following information:
   (The vendor should limit this response to no longer than five pages)

   a. How the vendor will engage Council Participants;
   b. How the vendor will ensure that the composition of the Council is diverse and representative of Specialty Plan membership; and
   c. A description of the stakeholder the vendors will engage to participate on the Council.

Addendum 02 revised Exhibit K.

EXHIBIT K

TECHNICAL PROPOSAL – ACCESS TO CARE – SPECIALTY PLAN

Directions for Vendor - The vendor should provide the information requested from the vendor's Access to Care, especially that related to the Specialty Plan requirements of the RFP. The vendor's response should align with the requirements specified in Section 3, Scope of Work – Specialty Plan, and Section 4 - Contractual Requirements.
******REMINDER – The combined Technical Proposal for the Specialty Plan should be no longer than 175 pages.***

In presenting the vendor's Access to Care, the vendor should discuss the following areas:

Network Development and Management – Network Adequacy Standards; Community-Based, Integrated, Trauma-Informed Services; Access to Specialty Providers; Network Gaps and Strategies; and Additional Health Benefits
(The vendor should limit this response to no longer than 15 pages)

1. The vendor should describe how the vendor will develop, manage, and monitor a comprehensive provider network that meets the Specialty Plan requirements and the complex needs of specialty plan members. The vendor's response should include the following:

    a. A description of adequate primary care, specialty care, dental services, and behavioral health provider networks to fulfill Specialty Plan requirements by:

        1) Provide documentation demonstrating that the vendor's primary care, specialty care, dental service, and behavioral health networks comply with travel distance standards as set forth by the Department of Commerce and Insurance (DCI) in 20 CSR 400-7.095 regarding Provider Network Adequacy Standards. The vendor 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 30 miles, unless the vendor can demonstrate that there is no licensed primary care, specialty care, dental service, and behavioral health provider in that area, in which case the vendor should ensure members have access to primary care, specialty care, dental service, and behavioral health providers within 60 miles. For any demonstrated access that differs from these standards, the vendor should submit proof of approval of the differences by DCI and should describe how the vendor will ensure that members in the counties with access differences approved by DCI are guaranteed access to the necessary providers.

        2) Provide documentation verifying the vendor's primary care, specialty care, dental service, and behavioral health network has adequate capacity. Such documentation should include, at a minimum, appointment availability, 24 hours/seven days a week access, sufficient experienced Primary Care, Specialty Care, Behavioral Health, and Dental Service providers to serve special needs populations, waiting times, open panels, and PCP to member ratios.

        3) Complete and submit applicable portions of Attachment 6 – Federally Qualified Health Clinics, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Family Planning, and STD Providers.

2. The vendor should describe their strategies for expanding the availability of community-based, trauma-informed, and integrated services to reduce unnecessary utilization of inpatient, emergency services, and out-of-home/out-of-state placements.

3. The vendor should describe their approach to ensuring Specialty Plan member access to Comprehensive Community Support (CCS) providers, practitioners certified in evidence-based practices, medical homes, crisis intervention providers, private and state-owned psychiatric residential treatment facilities, and providers currently contracted with MUPC.

EXHIBIT K, CONTINUED…

TECHNICAL PROPOSAL – ACCESS TO CARE – SPECIALTY PLAN

4. The vendor should identify provider network gaps and the vendor's strategies to address such.

Addendum 02 deleted the question below.

5. ***DELETED.***

Timely Access to Specialty Services and Trauma-Informed Care, Inpatient Hospital Boarding, and Non-Emergent Medical Transportation (NEMT) Services, In-Lieu of Services or Settings (ILOS), and Additional Health Benefits

1. The vendor should describe the vendor's approach to ensure that individually and systemically, Specialty Plan members are able to access trauma-informed and specialty services in a timely manner. ***(The vendor should limit this response to no longer than five pages)***

2. The vendor should describe the individual and systemic strategies the vendor will use to address the challenges presented when specialty Plan members in an inpatient hospital setting no longer require an inpatient level of care, but the hospital cannot discharge the member because a safe and appropriate placement or care is not available. ***(The vendor should limit this response to no longer than five pages)***

3. The vendor should provide a list of ILOS that the vendor will offer to Specialty Plan members. The vendor should include a description of the ILOS, the state plan services for which the ILOS is a cost-effective substitute, the expected start date for offering the ILOS, the target population, the anticipated capacity, and the expected outcomes. ***(The vendor should limit this response to no more than five pages)***

4. The vendor should provide a listing, description, and conditions under which the vendor proposes to offer additional health benefits to Specialty Plan members. ***(The vendor should limit this response to no more than three pages)***

5. The vendor should describe the vendor's considerations and approach to delivering NEMT in a manner that contemplates the needs of the Specialty Plan members and their families. The vendor should include the method of monitoring NEMT to ensure the transportation needs of Specialty Members and their families are met. ***(The vendor should limit this response to no longer than five pages)***

EXHIBIT L

TECHNICAL PROPOSAL – CARE MANAGEMENT – SPECIALTY PLAN

Directions for Vendor - The vendor should provide the information requested from the vendor's Care Management, especially that related to the Specialty Plan requirements of the RFP. The vendor's response should align with the requirements specified in Section 3, Scope of Work – Specialty Plan, and Section 4 - Contractual Requirements.
******REMINDER – The combined Technical Proposal for the Specialty Plan should be no longer than 175 pages.***

In presenting the vendor's Care Management, the vendor should discuss the following areas:

Specialty Plan Care Management (CM) Program

1. The vendor should describe the vendor's CM program for Specialty Plan members including how the vendor will meet the following CM requirements, and meet the principles of Specialty Plan care management (i.e., integrated, member/family-centered, trauma-informed, well-coordinated):
   (The vendor should limit this response to no more than 30 pages)

   a. Staffing;
   b. Training;
   c. CM tiers and assignment;
   d. CM coordination and accountability;
   e. DM approach;
   f. Care plan development;
   g. Ensuring services are authorized;
   h. Tracking referrals;
   i. Identifying and resolving service gaps;
   j. Supporting member transitions of care;
   k. CM information systems and analytics; and
   l. Individual and systemic CM monitoring.

Coordination with Other Entities

1. The vendor should describe how the vendor will provide CM and coordinate with other entities working with members, families, and resource providers to meet CM requirements and members' needs, while ensuring that the vendor does not duplicate care and case management activities performed by other entities.
   (The vendor should limit this response to no more than seven pages)

Consent

1. The vendor should describe the process for obtaining the necessary assent, consent, and informed consent for Specialty Plan members in the legal custody of the CD. The vendor should include the vendor's role and process for assisting an inpatient hospital to expeditiously obtain the consents necessary to begin treatment when a Specialty Plan member in the legal custody of CD is admitted. ***(The vendor should limit this response to no more than five pages)***

EXHIBIT L, CONTINUED…

TECHNICAL PROPOSAL – CARE MANAGEMENT – SPECIALTY PLAN

Use Cases

1. The vendor should describe how the vendor proposes to coordinate with providers, members/families/resource providers, and involved state agencies to provide CM to members in the following scenarios:

   a. The member is a 15-year-old girl from a family with multiple siblings. The member is pregnant, has a trauma history, and has a substance use disorder with history of using alcohol and methamphetamines. The member is being prescribed psychotropic medications from multiple providers for major depression and generalized anxiety disorder. Her family tried to find services from a provider certified in trauma-focused cognitive behavioral therapy but were not successful. The member is placed in residential treatment under the authority of CD. The CD informed consent policy requires the biological family to make decisions regarding psychotropic medications. ***(The vendor should limit this response to no more than five pages)***

   b. The member is a 10-year-old boy in foster care. The member has diabetes and needs a consultation with an endocrinologist. Due to behavioral issues that impact his learning, the member has an Individualized Education Plan and has already moved from one foster home to another. The foster family has several children they are caring for and are not engaging well with CM. Additionally, one of the foster parents has experienced hearing loss and has difficulty communicating by telephone. The member has been provided care through a medical home specializing in care for children in foster care. The biological family still has legal responsibility to make decisions regarding medications. ***(The vendor should limit this response to no more than five pages)***

EXHIBIT M

TECHNICAL PROPOSAL – MEDICAID REFORM AND TRANSFORMATION – SPECIALTY PLAN

Directions for Vendor - The vendor should provide the information requested from the vendor's Medicaid Reform and Transformation, especially that related to the Specialty Plan requirements of the RFP. The vendor's response should align with the requirements specified in Section 3, Scope of Work – Specialty Plan, and Section 4 - Contractual Requirements.
******REMINDER – The combined Technical Proposal for the Specialty Plan should be no longer than 175 pages.***

In presenting the vendor's Medicaid Reform and Transformation, the vendor should discuss the following areas:

State Provider Incentive Programs

1. The vendor should provide a description of the vendor's proposed provider incentive programs under the Specialty Plan and how such programs will be implemented in accordance with RFP requirements to improve member health outcomes, decrease inappropriate utilization of services, and decrease health risk factors in the populations the providers and provider groups serve. Such state provider incentive programs may include, at a minimum, the following provider types: primary care, behavioral health, CMHCs, FQHCs, RHCs, licensed clinical social workers, etc. If applicable, the vendor should describe the extent to which the vendor is currently offering provider incentive programs in Missouri or another state. ***(The vendor should limit this response to no more than six pages)***

Value-Based Purchasing

1. The vendor should describe how the vendor will establish the foundation necessary to introduce value-based purchasing strategies to the Specialty Plan program after the first 12 months of the contract, if requested by the state agency. ***(The vendor should limit this response to no more than six pages)***

EXHIBIT N

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 vendor is committing to participation by or if the vendor is a qualified MBE/WBE and/or organization for the blind/sheltered workshop and/or a qualified SDVE, the vendor must provide the required information in the appropriate table(s) below for the organization proposed and must submit the completed exhibit with the vendor'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 vendor 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 vendor 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.*
General Plan		
1.	%	Product/Service(s) proposed: RFP Paragraph References:
2.	%	Product/Service(s) proposed: RFP Paragraph References:
3.	%	Product/Service(s) proposed: RFP Paragraph References:
Total MBE Percentage:	**%**	
Specialty Plan		
1.	%	Product/Service(s) proposed: RFP Paragraph References:

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 vendor 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.*
2.	%	Product/Service(s) proposed: RFP Paragraph References:
3.	%	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 vendor 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.*
General Plan		
1.	%	Product/Service(s) proposed: RFP Paragraph References:
2.	%	Product/Service(s) proposed: RFP Paragraph References:
3.	%	Product/Service(s) proposed: RFP Paragraph References:
Total WBE Percentage:	**%**	
Specialty Plan		
1.	%	Product/Service(s) proposed: RFP Paragraph References:
2.	%	Product/Service(s) proposed: RFP Paragraph References:
3.	%	Product/Service(s) proposed: RFP Paragraph References:
Total WBE Percentage:	**%**	

Organization for the Blind/Sheltered Workshop Commitment Table

- 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.
- The vendor 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, at a minimum, the greater of $5,000 or 2% of the total dollar value of the contract for purchases not exceeding $10 million.
- The vendor may propose more than one organization for the blind/sheltered workshop as part of the vendor's total committed participation. However, the services performed or products provided must still meet the requirements noted herein.

Name of Organization for the Blind or Sheltered Workshop Proposed	**Committed Participation** ($ amount or % of total value of contract)	**Description of Products/Services to be Provided by Listed Organization for the Blind/Sheltered Workshop** *The vendor 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.*
General Plan		
1.	%	Product/Service(s) proposed: RFP Paragraph References:
2.	%	Product/Service(s) proposed: RFP Paragraph References:
Total Blind/Sheltered Workshop Percentage:	**%**	
Specialty Plan		
1.	%	Product/Service(s) proposed: RFP Paragraph References:
2.	%	Product/Service(s) proposed: RFP Paragraph References:
Total Blind/Sheltered Workshop Percentage:	**%**	

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 vendor 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.*
General Plan		
1.	%	Product/Service(s) proposed: RFP Paragraph References:
2.	%	Product/Service(s) proposed: RFP Paragraph References:
Total SDVE Percentage:	**%**	
Specialty Plan		
1.	%	Product/Service(s) proposed: RFP Paragraph References:
2.	%	Product/Service(s) proposed: RFP Paragraph References:
Total SDVE Percentage:	**%**	

EXHIBIT O

DOCUMENTATION OF INTENT TO PARTICIPATE

If the vendor 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 vendor must either provide this Exhibit or letter of intent recently signed by the proposed MBE/WBE, Organization for the Blind, Sheltered Workshop, and/or SDVE documenting the following information with the vendor's proposal.

~ Copy This Form For Each Organization Proposed ~

Vendor 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 vendor 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*

EXHIBIT O, 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 three (3) years to the Division of Purchasing (Purchasing), the vendor **must** provide the following SDV documents:

1. A copy of the SDV's Certificate of Release or Discharge from Active Duty (DD Form 214), and a copy of the SDV's disability rating letter issued by the Department of Veterans Affairs establishing a service connected disability rating, or a Department of Defense determination of service connected disability.

(NOTE: The SDV's Certificate of Release or Discharge from Active Duty (DD Form 214), and the SDV's disability rating letter issued by the Department of Veterans Affairs establishing a service connected disability rating, or Department of Defense determination of service connected disability shall be considered confidential pursuant to subsection 14 of Section 610.021, RSMo.)

The vendor should check the appropriate statement below and, if applicable, provide the requested information.

- o No, I have not previously submitted the SDV documents specified above to Purchasing and therefore have enclosed the SDV documents.

- o Yes, I previously submitted the SDV documents specified above within the past three (3) years to Purchasing.

  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 Purchasing SDVE database located at http://oa.mo.gov/sites/default/files/sdvelisting.pdf, then the SDV documents have been submitted to Purchasing within the past three [3] years. However, if it has been determined that an SDVE at any time no longer meets the requirements stated above, Purchasing will remove the SDVE and associated SDV from the database.)

FOR STATE USE ONLY

SDV Documents - Verification Completed By:

_____ _____

Buyer Date

EXHIBIT P

BUSINESS ENTITY CERTIFICATION, ENROLLMENT DOCUMENTATION, AND AFFIDAVIT OF WORK AUTHORIZATION

BUSINESS ENTITY CERTIFICATION:
The vendor 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.uscis.gov/e-verify.
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.

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, 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 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 P, 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 vendor must perform/provide each of the following. The vendor 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.uscis.gov/e-verify; 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 vendor's name and company ID OR a page from the E-Verify Memorandum of Understanding (MOU) listing the vendor's name and the MOU signature page completed and signed, at minimum, by the vendor and the Department of Homeland Security – Verification Division. If the signature page of the MOU lists the vendor'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 P, continued…

AFFIDAVIT OF WORK AUTHORIZATION:

The vendor 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 _____ of _____. I am
(DAY) (MONTH, YEAR)

commissioned as a notary public within the County of _____, State of
(NAME OF COUNTY)

_____, and my commission expires on _____.
(NAME OF STATE) (DATE)

_____ _____

Signature of Notary *Date*

EXHIBIT P, 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 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 vendor's name and the MOU signature page completed and signed by the vendor 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** to Which Previous E-Verify Documentation Submitted:
_____

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 Q

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.

EXHIBIT R
ANTI-DISCRIMINATION AGAINST ISRAEL ACT CERTIFICATION

Statutory Requirement: Section 34.600, RSMo, precludes entering into a contract with a company to acquire products and/or services "unless the contract includes a written certification that the company is not currently engaged in and shall not, for the duration of the contract, engage in a boycott of goods or services from the State of Israel; companies doing business in or with Israel or authorized by, licensed by, or organized under the laws of the State of Israel; or persons or entities doing business in the State of Israel."

Exceptions: The statute provides two exceptions for this certification: 1) "contracts with a total potential value of less than one hundred thousand dollars" or 2) "contractors with fewer than ten employees." Therefore the following certification is required prior to any contract award.

Section 34.600, RSMo, defines the following terms:

> **Company -** any for-profit or not-for-profit organization, association, corporation, partnership, joint venture, limited partnership, limited liability partnership, limited liability company, or other entity or business association, including all wholly-owned subsidiaries, majority-owned subsidiaries, parent companies, or affiliates of those entities or business associations.
>
> **Boycott Israel** and **Boycott of the State of Israel -** engaging in refusals to deal, terminating business activities, or other actions to discriminate against, inflict economic harm, or otherwise limit commercial relations specifically with the State of Israel; companies doing business in or with Israel or authorized by, licensed by, or organized under the laws of the State of Israel; or persons or entities doing business in the State of Israel, that are all intended to support a boycott of the State of Israel. A company's statement that it is participating in boycotts of the State of Israel; companies doing business in or with Israel or authorized by, licensed by, or organized under the laws of the State of Israel; or persons or entities doing business in the State of Israel, or that it has taken the boycott action at the request, in compliance with, or in furtherance of calls for a boycott of the State of Israel; companies doing business in or with Israel or authorized by, licensed by, or organized under the laws of the State of Israel; or persons or entities doing business in the State of Israel shall be considered to be conclusive evidence that a company is participating in a boycott of the State of Israel; companies doing business in or with Israel or authorized by, licensed by, or organized under the laws of the State of Israel; or persons or entities doing business in the State of Israel; provided, however that a company that has made no such statement may still be considered to be participating in a boycott of the State of Israel; companies doing business in or with Israel or authorized by, licensed by, or organized under the laws of the State of Israel; or persons or entities doing business in the State of Israel if other factors warrant such a conclusion.

Certification: The vendor must therefore certify their current status by completing either Box A, Box B, or Box C on the next page of this Exhibit.

BOX A:	To be completed by any vendor that does not meet the definition of "company" above, hereinafter referred to as "Non-Company."
BOX B:	To be completed by a vendor that meets the definition of "Company" but has less than ten employees.
BOX C:	To be completed by a vendor that meets the definition of "Company" and has ten or more employees.

EXHIBIT R, continued…

BOX A – NON-COMPANY ENTITY

I certify that _____ (Entity Name) currently **DOES NOT MEET** the definition of a company as defined in Section 34.600, RSMo, but that if awarded a contract and the entity's business status changes during the life of the contract to become a "company" as defined in Section 34.600, RSMo, and the entity has ten or more employees, then, prior to the delivery of any services and/or supplies as a company, the entity agrees to comply with, complete, and return Box C to the Division of Purchasing at that time.

_____ _____
Authorized Representative's Name (Please Print) Authorized Representative's Signature

_____ _____
Entity Name Date

BOX B – COMPANY ENTITY WITH LESS THAN TEN EMPLOYEES

I certify that _____ (Company Name) **MEETS** the definition of a company as defined in Section 34.600, RSMo, and currently has less than ten employees but that if awarded a contract and if the company increases the number of employees to ten or more during the life of the contract, then said company shall comply with, complete, and return Box C to the Division of Purchasing at that time.

_____ _____
Authorized Representative's Name (Please Print) Authorized Representative's Signature

_____ _____
Company Name Date

BOX C – COMPANY ENTITY WITH TEN OR MORE EMPLOYEES

I certify that _____ (Company Name) **MEETS** the definition of a company as defined in Section 34.600, RSMo, has ten or more employees, and is not currently engaged in a boycott of goods or services from the State of Israel; companies doing business in or with Israel or authorized by, licensed by, or organized under the laws of the State of Israel; or persons or entities doing business in the State of Israel as defined in Section 34.600, RSMo. I further certify that if the company is awarded a contract for the services and/or supplies requested herein said company shall not engage in a boycott of goods or services from the State of Israel; companies doing business in or with Israel or authorized by, licensed by, or organized under the laws of the State of Israel; or persons or entities doing business in the State of Israel as defined in Section 34.600, RSMo, for the duration of the contract.

_____ _____
Authorized Representative's Name (Please Print) Authorized Representative's Signature

_____ _____
Company Name Date

Addendum 02 revised Exhibit S.

EXHIBIT S

MISCELLANEOUS INFORMATION

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 vendor MUST disclose such fact and provide details in the space below or on an attached page.

Are any of the vendor'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://s1.sos.mo.gov/CMSImages/Library/Reference/Orders/2004/eo04_009.pdf)	Yes ____	No ____
If YES, mark the appropriate exemption below, and provide the requested details: 1. ____ Unique good or service. 1. EXPLAIN:_____ 2. ____ Foreign firm hired to market Missouri services/products to a foreign country. 2. Identify foreign country: _____ 3. ____ Economic cost factor exists 3. EXPLAIN:_____ 4. ____ Vendor/subcontractor maintains significant business presence in the United States and only performs trivial portion of contract work outside US. 1. 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: ___% 2. Specify what contract work would be performed outside the United States: _____		

Employee/Conflict of Interest:

Vendors 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 vendor or any owner of the vendor'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 vendor's organization held by elected or appointed official or employee of the State of Missouri or political subdivision thereof:	_____%

EXHIBIT S, continued…

MISCELLANEOUS INFORMATION

Registration of Business Name (if applicable) with the Missouri Secretary of State – The vendor should indicate the vendor's charter number and company name with the Missouri Secretary of State. Additionally, the vendor should provide proof of the vendor's good standing status with the Missouri Secretary of State. If the vendor is exempt from registering with the Missouri Secretary of State pursuant to Section 351.572, RSMo., identify the specific Section of 351.572 RSMo., which supports the exemption.

Charter Number (if applicable)	***Company Name***
If exempt from registering with the Missouri Secretary of State pursuant to Section 351.572 RSMo., identify the Section of 351.572 to support the exemption:	

Proposed Health Care Service Subcontractors – The vendor should identify each health care service subcontractor(s) proposed to whom the vendor will delegate any of the services required herein. Examples include, at a minimum, behavioral health services, vision services, or dental services. The vendor should describe the services and activities that will be provided by such subcontractor(s).

a. The vendor should provide the names, mailing address, and a description of the scope and portions of the work the proposed subcontractor(s) will perform.

b. The vendor should describe how the vendor intends to monitor and evaluate the health care subcontractor(s) performance.

c. The vendor 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 subcontractor within the past five years. In addition, the vendor should identify and describe any letter of deficiency issued as well as any corrective actions requested or required by any federal or state regulatory entity or state Medicaid agency within the past five years that relate to subcontractor Medicaid or CHIP contracts. The vendor should also address the subcontractors' parent organization, affiliates, and subsidiaries.

d. The vendor should specify whether there is any pending or recent (within the past five years) litigation against a proposed health care service subcontractor. This shall include, at a minimum, litigation involving failure to provide timely, adequate, or quality physical or behavioral health services. The vendor does not need to report workers' compensation cases. If there is pending or recent litigation against a health care service subcontractor, the vendor should 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. The vendor should also include any SEC filings discussing any pending or recent health care service subcontractor litigation. The vendor should address the subcontractors' parent organization, affiliates, and subsidiaries.

e. The vendor should indicate if, within the past five 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 vendor 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 vendor should provide a summary of the health care service subcontractor's court-approved reorganization plan. The vendor should address the health care service subcontractors' parent organization, affiliates, and subsidiaries.

EXHIBIT S, continued…

MISCELLANEOUS INFORMATION

Proposed Subcontractor Name and Address	Service Proposed to be Provided by the Proposed Subcontractor

HMO Status - If the vendor is not a federally qualified HMO, the vendor should disclose the following information on certain types of business transactions the vendor has with a "party in interest" as defined in the Public Health Services Act.

1. Any sale, exchange, or lease of any property between the vendor's organization and a "party in interest".

2. Any lending of money or other extension of credit between the vendor's organization and a "party in interest".

3. Any furnishing for consideration of goods, services (including management services), or facilities between the vendor'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.

4. If the vendor has operated previously in the commercial or Medicare markets, the vendor shall disclose the information listed below regarding business transactions for the previous year. The vendor shall report all of the vendor's business transactions, not just the transactions relating to serving the Managed Care Program enrollment:

EXHIBIT S, continued…

MISCELLANEOUS INFORMATION

a. The name of the "party of interest" for each business transaction;
b. A description of each business transaction and the quantity or units involved;
c. The accrued dollar value of each business transaction during the fiscal year; and
d. Justification of the reasonableness of each business transaction.

5. The vendor should submit proof that the vendor has a Certificate of Authority from the Missouri Department of Insurance, Financial Institutions, and Professional Registration to operate as HMO and that its service area includes each county specified herein.

   a. If the vendor does not currently have a certificate of authority, the vendor should provide documentation that the vendor has or will submit an application to the Department of Insurance, Financial Institutions & Professional Registration for such certification.

   b. If the vendor is new to the MO HealthNet Managed Care Program, the vendor should begin the application process with the Department of Insurance, Financial Institutions, and Professional Registration in sufficient time to ensure appropriate licensure by January 10, 2022. The vendor may contact Cindy Monroe, Admissions Specialist, with DCI via email at Kephan.Merancis@insurance.mo.gov or via telephone at 573-751-4362 for assistance with the HMO licensure application process.

Information Relating to Ownership and Control

The vendor should disclose the following in the format specified in "*Ownership or Controlling Interest Disclosure", "Transaction Disclosures",* and *"Provider and Subcontractor Disclosure"* located on the Managed Care Program website under Reporting Schedules and Templates.

1. The name and address of any person (individual or corporation) with an ownership or control interest in the vendor's organization, or in any provider or subcontractor in which the vendor has an ownership of 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 vendor's organization has an ownership or control interest.

4. The name, address, and date of birth of any managing employee of the vendor's organization.

Information Relating to Criminal Convictions

1. The vendor should identity any person who has an ownership or controlling interest in the vendor's organization, or is an agent or managing employee of the vendor'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.

EXHIBIT S, CONTINUED…

MISCELLANEOUS INFORMATION

Information Relating to Significant Business Transactions

1. The vendor should identify any provider or subcontractor with whom the vendor's organization has had business transactions totaling more than $25,000.00 during the previous 12-month period, ending on the date of disclosure.

2. If the vendor is new to the MO HealthNet Managed Care Program, but the vendor has operated previously in the commercial or Medicare markets, the vendor should provide information on business transactions for the previous year, ending on the date of disclosure.

3. Financial statements for individuals with more than 5% of ownership interest should be submitted.

4. The vendor should provide certification that the vendor 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. Certification should be provided in the form of a notarized attestation letter signed by one of the following individuals:

   a. The vendor's CEO;
   b. The vendor's CFO; or
   c. An individual who has delegated authority to sign for, and who reports directly to, the vendor's CEO or CFO.

5. The vendor should provide the following financial information pertaining to the vendor's organization (the legal entity that is submitting the proposal and that will be the party responsible for any contract awarded):

Addendum 02 added and deleted language from the question below.

   a. Audited financial statements and balance sheets for three previous years, or as many years up to three years that the entity has been in operation. If the vendor has not been in operation for at least one year, the vendor shall submit unaudited financial statements and balance sheets. If the vendor is an existing HMO, a financial statement should be submitted on the form specified by the National Association of Insurance Companies (NAIC) and should include ***the Actuarial Opinion as a supplement to the annual NAIC financial statement.***

   b. The following information should be submitted in table format regarding the most recent financial statements:

      1) Working capital;
      2) Current ratio;
      3) Quick ratio;
      4) Net worth; and
      5) Debt-to-worth ratio.

   c. Financial plans for the vendor's current fiscal year.

   d. Information about the vendor's financial forecasts for the original contract period and potential contract renewal periods. These forecasts should include income statements and enrollment forecasts.

   e. A statement of whether there is any pending or recent (within the past five years) litigation against the vendor. This should include, at a minimum, litigation involving failure to provide timely, adequate, or quality physical or behavioral health services. The vendor does not need to report workers' compensation cases. If there is a pending or recent litigation against the vendor, the vendor should describe the damages

EXHIBIT S, CONTINUED…

MISCELLANEOUS INFORMATION

being sought or awarded and the extent to which adverse judgement is/would be covered by insurance or reserves set aside for this purpose. The vendor should 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 vendor's performance in a contract. The vendor should also include any Securities and Exchange Commission (SEC) filings discussing any pending or recent litigation. Furthermore, the vendor should address the vendor's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

f. A statement of whether, within the past five years, the vendor 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 vendor should provide an explanation providing relevant details including the date in which the vendor emerged from bankruptcy or expects to emerge. If still in bankruptcy, the vendor should provide a summary of the court-approved reorganization plan. The vendor should also address the vendor's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

g. As applicable, the vendor should provide, in table format, the vendor's current ratings, as well as ratings for each of the past three years from the following rating agencies. The vendor should also address the vendor'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/ies.

h. The vendor should provide the names of independent auditors.

6. The vendor should provide documentation of insurance coverage such as a list of insurers used, including contact person and address, and the type and amounts of each policy held.

7. The vendor should provide proof of reinsurance.

8. The vendor 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 vendor within the past five years. If there have been any such investigations, the vendor should provide an explanation with relevant details and an explanation of the outcome. The vendor should also provide a statement of whether there are any current or pending SEC investigations, civil or criminal, involving the vendor. If current or pending SEC investigations are in progress, the vendor should provide an explanation of relevant details and an opinion of counsel as to whether the pending investigation(s) will impair the vendor's performance in a contract. The vendor should address the vendor's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

b. A statement of whether the vendor is currently the subject, or has recently (within the past five 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 vendor is or has recently been the subject of such an investigation, the vendor should provide an explanation with relevant details and an explanation of the outcome. The vendor shall address the vendor's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

EXHIBIT S, CONTINUED…

MISCELLANEOUS INFORMATION

Personnel/Staffing

1. The vendor 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 vendor should submit the following information:

   a. The number of employees, client base, and location of office(s);

   b. The vendor's parent company, affiliates, and subsidiaries, if any;

Addendum 02 added a word to the question below.

   c. Resumes, job descriptions, and full-time equivalent status for the vendor's Missouri-based Health Plan Administrator, Medical Director, Quality Assessment and Improvement ***Coordinator***, Utilization Management Coordinator, Special Programs Coordinator, Care Management Supervisor, Behavioral Health Coordinator, and Chief Financial Officer;

   d. Identification of which, if any, of the key positions, including administrative personnel identified herein, are not already filled. The vendor should provide rationale for why positions are not filled and should provide timeframe for filling positions prior to readiness review activities;

   e. Information for other personnel as specified herein, including Dental Consultants; Complaint, Grievance, and Appeal Coordinator; Claims Administrator/MIS Director, and Compliance Officer;

   f. Information on staffing levels, job descriptions, and qualifications for Prior Authorization Staff, Inpatient Certification Review Staff, Member Services Staff, and Provider Services Staff.

Claims Payment Process

1. The vendor should submit the following information regarding the vendor's claims payment process:

   a. Information describing the vendor's claim adjudication processes. The vendor should provide a flow chart or written description that details the flow of claims from receipt until payment. Information should be provided documenting the vendor's audit trail of all claims that enter the system and any review processes that are in place;

   b. Documentation of the vendor's past and current performance with regard to the timely payment to in-network and out-of-network providers; and

   c. A description of the vendor's claims processing and management information system functions, including, at a minimum, information about the vendor's liability management practices regarding its "Incurred But Not Reported Claims" and "Received But Unadjudicated Claims".

Additional Requested Information

1. Member Services and Provider Services - The vendor 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.

EXHIBIT S, CONTINUED…

MISCELLANEOUS INFORMATION

2. Member Grievance System – The vendor should describe the vendor'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.

Addendum 02 deleted a repetitive word from the question below.

3. Health Plan Under Utilization Monitoring System - The vendor should describe how the vendor 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 vendor should outline how the vendor will investigate and correct the problem or problems which resulted in such underutilization of services if under-utilization is identified. In addition, the vendor should describe the vendor's ongoing review process of service denials and ongoing utilization monitoring system.

4. Release for Ethical Reasons - The vendor should state if reimbursement for, or provider coverage of, a counseling or referral service will be objected to based on moral or religious grounds.

5. Implementation Plan - The vendor should submit an implementation plan that identifies and elaborates on the critical actions the vendor will pursue to implement the programmatic responsibilities and performance requirements outlined herein. Submission of the implementation plan in no way affects the vendor'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. The process for communicating with new members, including the methods, materials, and timeframes;
    d. The process for communicating with providers regarding implementation and expectations, including methods, materials, and timeframes;
    e. The process for identifying, tracking, and resolving issues during the first 60 calendar days of implementation, including triaging priority issues;

Addendum 02 revised the question below.

    f. A list and description of tasks critical to a successful ***implementation*** which the vendor expects to complete prior to the contract award date, and the proposed dates of completion;
    g. A list and description of tasks critical to the successful implementation which the vendor expects to complete prior to the contract effective date, and the proposed dates of completion; and
    h. A list and description of significant tasks which will be completed after the contract effective date, along with the proposed dates of completion and an explanation as to why these tasks will not be completed by the contract effective date.

Attachments 1-6

Attachments 1-6 are separate links that must be downloaded separately from the MissouriBUYS Statewide eProcurement System at:
https://missouribuys.mo.gov/bidboard.html.

STATE OF MISSOURI
DIVISION OF PURCHASING
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 addendum 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 (Purchasing)**. The agency is also responsible for payment.
b. **Addendum** means a written, official modification to an RFP.
c. **Amendment** means a written, official modification to a contract.
d. **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.
e. **Proposal End Date and Time** and similar expressions mean the exact deadline required by the RFP for the receipt of sealed proposals.
f. **Vendor** means the supplier, offeror, 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.
g. **Buyer** means the procurement staff member of Purchasing. The **Contact Person** as referenced herein is usually the Buyer.
h. **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.
i. **Contractor** means a supplier, offeror, person, or organization who is a successful vendor as a result of an RFP and who enters into a contract.
j. **Exhibit** applies to forms which are included with an RFP for the vendor to complete and submit with the sealed proposal prior to the specified end date and time.
k. **Request for Proposal (RFP)** means the solicitation document issued by Purchasing to potential vendors 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 Addendums thereto.
l. **May** means that a certain feature, component, or action is permissible, but not required.
m. **Must** means that a certain feature, component, or action is a mandatory condition.
n. **Pricing Page(s)** applies to the form(s) on which the vendor 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 vendor with the sealed proposal prior to the specified proposal end date and time.
o. **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 Purchasing.
p. **Shall** has the same meaning as the word must.
q. **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 Purchasing.
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 vendor's responsibility to ask questions, request changes or clarification, or otherwise advise Purchasing 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 vendors regarding specifications, requirements, competitive proposal process, etc., must be directed to the buyer from Purchasing, unless the RFP specifically refers the vendor to another contact. Such e-mail, fax, or phone communication should be received at least ten calendar days prior to the official proposal end date.
b. Every attempt shall be made to ensure that the vendor receives an adequate and prompt response. However, in order to maintain a fair and equitable procurement process, all vendors will be advised, via the issuance of an addendum to the RFP, of any relevant or pertinent information related to the procurement. Therefore, vendors are advised that unless specified elsewhere in the RFP, any questions received less than ten calendar days prior to the RFP end date may not be answered.
c. Vendors are cautioned that the only official position of the State of Missouri is that which is issued by Purchasing in the RFP or an addendum thereto. No other means of communication, whether oral or written, shall be construed as a formal or official response or statement.
d. Purchasing monitors all procurement activities to detect any possibility of deliberate restraint of competition, collusion among vendors, price-fixing by vendors, or any other anticompetitive conduct by vendors 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 MissouriBUYS Statewide eProcurement System. Registered vendors are electronically notified of those proposal opportunities that match the commodity codes for which the vendor registered in MissouriBUYS. If a registered vendor's e-mail address is incorrect, the vendor must update the e-mail address themselves on the state's MissouriBUYS Statewide eProcurement System at https://missouribuys.mo.gov/ .
f. Purchasing reserves the right to officially amend or cancel an RFP after issuance. It shall be the sole responsibility of the vendor to monitor the MissouriBUYS Statewide eProcurement System to obtain a copy of the addendum(s). Registered vendors who received e-mail notification of the proposal opportunity when the RFP was established and registered vendors who have responded to the RFP on-line prior to an addendum being issued should receive e-mail notification of the addendum(s). Registered vendors who received e-mail notification of the proposal opportunity when the RFP was

established and registered vendors who have responded to the proposal on-line prior to a cancellation being issued should receive e-mail notification of a cancellation issued prior to the exact end date and time specified in the RFP.

4. PREPARATION OF PROPOSALS

a. Vendors **must** examine the entire RFP carefully. Failure to do so shall be at the vendor'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 vendor 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 vendor 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 vendor 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 a vendor may submit a proposal which contains a list of statutory limitations and identification of those prohibitive clauses. The vendor 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 Purchasing or (2) be accepted without further clarification if the statutory limitations and prohibitive clauses are deemed acceptable by Purchasing. If Purchasing 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 vendor 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. Registered vendors may submit proposals electronically through the MissouriBUYS Statewide eProcurement System at https://missouribuys.mo.gov/ or by delivery of a hard copy to the Purchasing office. Vendors that have not registered on the MissouriBUYS Statewide eProcurement System may submit proposals hard copy delivered to the Purchasing office. Delivered proposals must be sealed in an envelope or container, and received in the Purchasing office located at 301 West High St, Rm 630 in Jefferson City, MO no later than the exact end date and time specified in the RFP. All proposals must (1) be submitted by a duly authorized representative of the vendor's organization, (2) contain all information required by the RFP, and (3) be priced as required. Hard copy proposals may be mailed to the Purchasing post office box address. However, it shall be the responsibility of the vendor to ensure their proposal is in the Purchasing office (address listed above) no later than the exact end date and time 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 end 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 vendor may be modified on-line prior to the official end date and time. A proposal which has been delivered to the Purchasing office may be modified by signed, written notice which has been received by Purchasing prior to the official end date and time specified. A proposal may also be modified in person by the vendor or its authorized representative, provided proper identification is presented before the official end date and time. Telephone or telegraphic requests to modify a proposal shall not be honored.
d. A proposal submitted electronically by a registered vendor may be retracted on-line prior to the official end date and time. A proposal which has been delivered to the Purchasing may only be withdrawn by a signed, written document on company letterhead transmitted via mail, e-mail, or facsimile which has been received by Purchasing prior to the official end and time specified. A proposal may also be withdrawn in person by the vendor or its authorized representative, provided proper identification is presented before the official end 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 vendor. Justification of withdrawal decision may include a significant error or exposure of proposal information that may cause irreparable harm to the vendor.
f. When submitting a proposal electronically, the registered vendor indicates acceptance of all RFP requirements, terms and conditions by clicking on the "Accept" button on the Overview tab. Vendors delivering a hard copy proposal to Purchasing must sign and return the RFP cover page or, if applicable, the cover page of the last addendum thereto in order to constitute acceptance by the vendor of all RFP requirements, terms and conditions. Failure to do so may result in rejection of the proposal unless the vendor's full compliance with those documents is indicated elsewhere within the vendor'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 end 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 MissouriBUYS Statewide eProcurement System. The contents of the responses shall not be disclosed at this time.
b. Proposals which are not received in the Purchasing office prior to the official end 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 vendor 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 a vendor shall be subject to evaluation if deemed by Purchasing to be in the best interest of the State of Missouri.
c. The vendor 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 vendor 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 vendor, 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 vendors fail to meet the same mandatory requirement in an RFP, Purchasing reserves the right, at its sole discretion, to waive that requirement for all vendors and to proceed with the evaluation. In addition, Purchasing reserves the right to waive any minor irregularity or technicality found in any individual proposal.
f. Purchasing 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 a vendor, from vendor’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 vendors 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 vendors.
j. Any award of a contract shall be made by notification from Purchasing to the successful vendor. Purchasing 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 Purchasing 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. Purchasing posts all proposal results on the MissouriBUYS Statewide eProcurement System for all vendors to view for a reasonable period after proposal award and maintains images of all proposal file material for review. Vendors who include an e-mail address with their proposal will be notified of the award results via e-mail.
m. Purchasing reserves the right to request clarification of any portion of the vendor’s response in order to verify the intent of the vendor. The vendor 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.
o. The final determination of contract(s) award shall be made by Purchasing.

9. CONTRACT/PURCHASE ORDER

a. By submitting a proposal, the vendor 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, addendums 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) Purchasing'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 Purchasing 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 Purchasing.
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 Purchasing, (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, Purchasing may cancel the contract. At its sole discretion, Purchasing 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 Purchasing 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, Purchasing will issue a notice of cancellation terminating the contract immediately. If it is determined Purchasing improperly cancelled the contract, such cancellation shall be deemed a termination for convenience in accordance with the contract.
c. If Purchasing cancels the contract for breach, Purchasing 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 Purchasing 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 vendor/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 vendor/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 Purchasing immediately.
b. Upon learning of any such actions, Purchasing 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, Purchasing shall take appropriate enforcement action which may include, but not necessarily be limited to, cancellation of the contract, suspension, or debarment by Purchasing 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 the vendor’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.

Revised 06-27-19